PRINTED: 04/17/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF	
		17E071	B. WIN	IG		04/1	1/2012
	ROVIDER OR SUPPLIER	cu	•	5	REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 FRIBUNE, KS 67879		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	The following citation Health Resurvey.	ns represent the findings of a					
	facility on 4/17/12	deficiencies was sent to the					
F 247 SS=D	483.15(e)(2) RIGHT ROOM/ROOMMATE		F	247			
		ht to receive notice before r roommate in the facility is					
	by: The facility reported	is not met as evidenced a census of 25 residents eview and 2 reviewed for r roommate change.					
	review, the facility fail reviewed residents re	n, interview, and record ed to ensure 1 of the 2 aceived notice before a commate (Resident #17).					
	Findings included:						
	(Mountain Standard 1 the facility moved his	on 4/2/12 at 2:47 p.m. MST Fime), resident #17 reported //her belongings without to another room while edical appointment.					
	Activity/Social Service expected administrati residents' concerns re	n 4/4/12 at 2:51 p.m. MST., e Staff D reported the facility ve staff to address egarding roommate issues. e Staff D reported a lack of					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		17E071	B. WIN	IG	·····	04/1	1/2012
	ROVIDER OR SUPPLIER	си	.	5	REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 FRIBUNE, KS 67879	, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 247	awareness that reside room. Resident #17's 12/30. (Minimum Data Set) r Observations on 4/4/r resident #17 as alert a bedroom recliner, and to room and roommat. During an interview or resident #17 reported his/her belongings whappointment in another reported he/she recall change with staff priodid not choose a room Resident #17 reported did not receive notificanew roommate, as we revealed staff moved from one room to another attended an appointment staff notified family buresident #17 received the room change. Review of resident #1 a lack of documentation new roommate in October 1 and	ent #17 moved from his/her 211 Quarterly MDS eported intact cogntion. 12 at 3:10 p.m. revealed and oriented, sat in his/her direcalled the events related e changes without difficulty. 12 at 3:11 p.m. MST, 13 at 3:11 p.m. MST, 14 at 3:11 p.m. MST, 15 at 3:11 p.m. MST, 16 at 3:11 p.m. MST, 17 at 4/4/12 at 3:11 p.m. MST, 18 at 4/4/12 at 3:11 p.m. MST, 19 at 4/4/12 at 3:11 p.m. MST, 19 at 4/4/12 at 3:11 p.m. MST, 10 at 8/21/11, staff moved all he/she attended an er town. Resident #17 and discussing a room are to 8/21/11 but the resident are no new roommate. 18 at 10 at	F	247			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SUF COMPLET	
			A. BUIL	DING			
		17E071	B. WING	3		04/1	1/2012
	COUNTY HOSPITAL LT	cu		506	ET ADDRESS, CITY, STATE, ZIP CODE THIRD PO BOX 338 BUNE, KS 67879		
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F 247	Service Staff D report 8/21/11. Activity/Soc he/she recalled reside room change some till lacked awareness of change rooms. During an interview of Administrative Nursing awareness of which such ange with resident August 2011. Admin confirmed documental resident received a ceither in August 2011. The facility failed to expend the support of the supp	ted not being on duty on ial Service Staff D reported ent #17 stated a wish for a me in August 2011 but a decision by the resident to a 4/5/12 at 9:19 a.m. MST, ag Staff A reported a lack of staff discussed the room #17 prior to the move in istrative Nursing Staff A etion failed to show the hoice of room or roommate or October 2011.	F:	247			
F 279 SS=D	483.20(d), 483.20(k)(COMPREHENSIVE COMPREHENSIVE COMPREHEN	e results of the assessment of revise the resident's of care. elop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial fied in the comprehensive	F:	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E071	B. WIN	3	 	04/1	1/2012
	COUNTY HOSPITAL LT	-cu	•	506 T	ADDRESS, CITY, STATE, ZIP CODE CHIRD PO BOX 338 CUNE, KS 67879	<u>, </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	due to the resident's §483.10, including th under §483.10(b)(4).	e 3 83.25 but are not provided exercise of rights under e right to refuse treatment Γ is not met as evidenced	F	279			
	The facility reported with 12 sampled for r Based on observation review, the facility fail assessment to developlan that included me	n, interview, and record led to use the results of an op a comprehensive care easurable objectives and of the 12 sampled resident's					
	for resident #17 inclufailure to thrive, dehyvitamin B deficiency, hypopotassemia, atytobacco use disorder Parkinson's disease, cerebral aneurysm nobstruction, dyspeps bladder, osteoarthrosof venous thrombosisterm use of anticoagum. The 9/29/2011 Annual assessment for resident required supposed in the sident required	pical depressive disorder, Alzheimer's disease, essential hypertension, onruptured, chronic airway ia, constipation, neurogenic sis, insomnia, edema, history s and embolism, and long ulants. al MDS (minimum data set)					

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				X3) DATE SURVEY COMPLETED			
		17E071	B. WIN	G		04/1	1/2012
	COUNTY HOSPITAL LT	си	•	50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	or since the prior assection of the 12/30/2011 Quarter set) assessment for register as cognitively balance and required staff for bed mobility, Resident #17 sustains or since the prior assection of the prior assessment) summare had a history of falls at the prior assessment complete score of "10" indicating fall risk. Record review of residual risk. Resident #17's 4/3/20 indicated the resident walker with supervision a wheel chair for long lacked identification of related to fall prevention related to fall prevention of the prior of the prior of the prior asset the prior	terly MDS (minimum data esident #17 identified the y intact with unsteady limited assistance of one transfers, and ambulation. ed no falls since admission essment. 2011 CAAs (care area y for falls indicated he/she and remained at risk for falls. 2011 CAAs (care area y for falls indicated he/she and remained at risk for falls. 2011 CAAs (care area y for falls indicated he/she and remained at risk for falls. 2011 CAAs (care area y for falls indicated he/she and remained at risk for falls. 2011 CAAs (care area y for falls indicated he/she and remained at risk for falls. 2012 All risk and on 12/30/2011 revealed a g the resident remained and in his/her room and used distances. The care plan f goals or interventions on for resident #17. 2012 Se's notes for 3/12/2012 at that in Standard Time) or attempted to get out of bed	F	279			

Facility ID: H036101

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SUR COMPLETE	
		17E071	B. WIN	3		04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	CU	•	506 7	T ADDRESS, CITY, STATE, ZIP CODE THIRD PO BOX 338 BUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280 SS=D	MST, direct care staff #17 out of bed and to used his/her four- who steps, and shuffled the During an interview of MST, administrative resident #17 had a higlacked interventions to The 2/21/2008 fall pointhat "all residents adminisk for falls due to agand changes in environ complete a fall risk as plan of care for the resident that included metimetables to meet the in the comprehensive #17 related to falls. 483.20(d)(3), 483.10(PARTICIPATE PLAN The resident has the incompetent or otherwincapacitated under the participate in planning changes in care and to A comprehensive assessinterdisciplinary team	n on 4/4/2012 at 8:50 a.m. K and L assisted resident the bathroom. Resident #17 eeled walker, took short e left foot on the floor. n 4/5/2012 at 10:00 a.m. hursing staff C verified that gh fall risk and the care plan to prevent falls. licy and procedure indicated nitted to this facility had a e, diagnoses, medications, forment. Staff should desessment and develop a sidents." see the results of an op a comprehensive care asurable objectives and de resident's needs identified assessment for resident k)(2) RIGHT TO NING CARE-REVISE CP right, unless adjudged vise found to be the laws of the State, to g care and treatment or treatment. e plan must be developed		280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL DING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WIN				
NAME OF PR	ROVIDER OR SUPPLIER	17E071			EET ADDRESS, CITY, STATE, ZIP CODE	04/1	1/2012
GREELEY	COUNTY HOSPITAL LT	CU		50	06 THIRD PO BOX 338		
	OLINANA DV. OT	ATEMENT OF DEFICIENCIES		TH	RIBUNE, KS 67879	IONI	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	disciplines as determ and, to the extent pra the resident, the resid legal representative;	e 6 other appropriate staff in ined by the resident's needs, icticable, the participation of dent's family or the resident's and periodically reviewed in of qualified persons after	F	280			
	by: The facility reported with 12 residents san Based on observation review, the facility fail of the 12 sampled residently failed to review plan after he/she exploss of 6.6% over a or 8.2% weight loss over facility failed to imple address the weight loweight loss. The facil review/revise resident placement of an indw Findings included: The signed Physic for resident #9 includ mellitus, vascular der syndrome, Alzheimer	n, interview and record led to evaluate and revise 2 sident's care plan. The livrevise resident #9's care lerienced a severe weight line month period and an line a 3 month period. The line ment interventions to less and prevent additional lity also failed to lity al					

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		17E071	B. WIN	IG_		04/1	1/2012
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	CU	•	5	REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 FRIBUNE, KS 67879		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	The 12/25/2011 Quarset) assessment for resident as rarely or resident and routh, weight loss, consume had mouth pain or different assessment) summar indicated he/she need assistance with meals Resident #9's 4/4/201 indicated he/she need monitored, may need diet, and had a goal of Resident #9's care play of 149.5 pounds on 1.2/19/2012, and 137 p. The care plan lacked interventions related to r loss. The care plan calorie diet, however, goals or interventions. Record review of the o 12/27/2011 weight 10 3/25/2012 weight 13 From 2/26/2012 weight 13 Sustained a 9.5 pound month. From 12/27/2011 to 3/25/2011 to	terly MDS (minimum data esident #9 identified the ever understood. Resident revealed a total ssistance of one for oral desident #9 tended to hold did not have a reported d a therapeutic diet, and ficulty with chewing. 11 CAAs (care area y for nutritional status ded soft foods and s. 2 nursing care plan ded to have weight to have a reduced calorie of no significant weight gain. In an also included the weights (8/2012, 145.5 pounds on counds as the current weight. Specific goals or on the resident's weight gain mentioned a reduced did not include specific to achieve these goals. Weekly weights: 147 pounds 14.5 pounds 15.5 pounds 15.5 pounds 16.5 pounds 16.6 pounds 16.6 pounds 16.5 pounds 16.5 pounds 16.5 pounds 16.6	F	280			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING		(X3) DATE SUF	
		17E071	B. WIN	IG		04/1	1/2012
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879		
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F 280	MST (Mountain Standarceived assistance was small bites of egg, cheminutes, and required continue eating. During an observation MST, resident #9 recellunch, took small bites mashed potatoes and for several minutes are to continue eating. During an interview of MST, administrative mashed had weight implement intervention loss. During an interview of (Mountain Standard The/she completed the resident #9's care planareflect the resident #9's care planareflect the resident weight loss. The facility failed to refer to the severe weight loss of period and an 8.2% was period. The facility failed to refer to the facility failed to refer	an on 4/4/2012 at 10:00 a.m. lard Time), resident #9 with eating breakfast, took ewed each bite for several encouragement to an on 4/4/2012 at 12:00 p.m. eived assistance with eating sof turkey with gravy, spinach, chewed each bite and required encouragement an 4/4/2012 at 5:15 p.m. eursing staff A verified at loss and staff failed to ans related to the weight an 4/4/2012 at 3:15 p.m. MST ime), dietary staff H verified nutritional portion of an and that portion did not current condition and did not cons needed to manage the evise and update resident the resident experienced a 6.6% over a one month reight loss over a 3 month led to implement ss the weight loss and	F	280			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SUF	
		17E071	B. WIN	IG _		04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си	l		REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 TRIBUNE, KS 67879	, , , , , ,	
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F 280	included diagnoses of hypokalemia, hypoma failure exacerbation, with left face/arm/leg insufficiency, restless fibrillation, controlled peripheral vascular distenosis, hypertension arthritis. The 3/27/12 an order to place an included to place an included to goals or included no goals or included no goals or included to use of an	a/12 physician's orders f acute gastroenteritis, agnesia, congestive heart cerebrovascular accident paralysis, renal leg syndrome, atrial type 2 diabetes mellitus, sease, lumbar spinal n, and degenerative knee physician's orders included ndwelling urinary catheter. 2 Quarterly MDS (Minimum nt reported moderately o urinary appliance, and of urine. at care plan, dated 9/28/11, ndividualized interventions dwelling bladder catheter. 2 nursing notes reported an indwelling urinary c technique. 5's clinical record revealed ewed/revised the care plan ndwelling bladder catheter 12 at 6:35 a.m. MST Time) revealed Direct Care dent #15 in a wheelchair nary catheter covered under	F	280			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	LTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLE	
		17E071	B. WING	S	. 04/ ⁻	11/2012
	COVIDER OR SUPPLIER COUNTY HOSPITAL LT	СП		STREET ADDRESS, CITY, STATE, Z 506 THIRD PO BOX 338 TRIBUNE, KS 67879	•	
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F 280	failed to update reside placement of an indw The facility failed to re	e 10 g Staff C confirmed staff ent #15's care plan after elling urinary catheter. eview/revise resident #15's nent of an indwelling urinary	F 2	280		
F 315 SS=D	483.25(d) NO CATHE RESTORE BLADDER Based on the resident assessment, the facility resident who enters the indwelling catheter is resident's clinical concatheterization was now ho is incontinent of the treatment and service infections and to rester function as possible. This REQUIREMENT by: The facility reported in the service in the facility reported in the service in the servi	t's comprehensive ty must ensure that a ne facility without an not catheterized unless the dition demonstrates that ecessary; and a resident bladder receives appropriate es to prevent urinary tract ore as much normal bladder is not met as evidenced a census of 25 residents	F 3	315		
	residents utilized indv Based on observatior review, the facility fail residents had valid m use of an indwelling of Findings included:	12 physicians order sheet onic ischemic heart				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E071	B. WIN	G		04/1	1/2012
	COUNTY HOSPITAL LT	си	•	50	EET ADDRESS, CITY, STATE, ZIP CODE 16 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 315	iron deficiency anemiextrapyramidal diseas movement disorders, esophagitis, urinary franticoagulants, insomosteoarthrosis. The Admission (MDS 11/23/11 and the Quaassessments for resident had moderat indwelling catheter, and The 11/23/11 Care Arsummary indicated thindwelling catheter. Resident #18's Care If the resident required care, assistance with staff to record amoun catheter, and monitor Review of the clinical justification for the us reevaluation for continuity of the continuity of the difference of the back of the wheel During an interview or resident #18 indicated	sm, vitamin D deficiency as, rhythmic disorder, other ses and abnormal congestive heart failure, requency, long-term use of ania, calculus of kidney, and) minimal Data Set on arterly MDS on 1/3/12 dent #18 indicated the ely impaired cognition, an and no toileting program. The a Assessment (CAA) are resident used an Plan dated 1/4/12 indicated staff assist with personal catheter care, instructed at of output from the fluids. The catheter or nued use of the catheter. The MST (mountain standard N and direct care for resident ne catheter in a pouch on	F	315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED		
		17E071	B. WIN	IG		04/1	1/2012	
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	си	•	5	REET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879			
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F 315	Continued From page	e 12 n 4/4/12 at 12:30 p.m. MST,	F	315				
	licensed staff B revea in and out of the facili had not always had a	led resident #18 had been ty several times. He/she foley during past visits. amily requested to have the						
	administrative staff A	theter use or valid medical						
F 323 SS=G	The facility failed to e justification for the use catheter for resident # 483.25(h) FREE OF # HAZARDS/SUPERVI	e of an indwelling foley #18. ACCIDENT	F	323				
	as is possible; and ea	as free of accident hazards						
	by:	is not met as evidenced a census of 25 with 12 were reviewed for						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 323	accidents. Based on observation review, the facility fail received adequate su accidents for 1 of 3 (# The facility also failed environment remaine hazards as possible. residents as independimpaired. This includ chemicals stored in a and water temperatur in commons areas that (Fahrenheit). (#29, # Findings included: - The signed Physicial for resident #17 included failure to thrive, dehys vitamin B deficiency, hypopotassemia, atyptobacco use disorder, Parkinson's disease, cerebral aneurysm no obstruction, dyspepsi bladder, osteoarthros of venous thrombosis use of anticoagulants The 9/29/2011 Annual assessment for resider resident as cognitively	an, interview and record ed to ensure each resident pervision to prevent ed to ensure the resident pervision to prevent ed to ensure the resident does free of accident The facility reported 9 dently mobile and cognitively ed potentially hazardous reas accessible to residents es in 6 resident rooms and eat exceeded 120 degree F 2, #17, #23, #18, and #6). an Orders dated 3/1/2012 ded diagnoses of adult dration, hypothyroidism, vitamin D deficiency, pical depressive disorder, Alzheimer's disease, essential hypertension, puruptured, chronic airway an, constipation, neurogenic is, insomnia, edema, history and embolism, long term al MDS (minimum data set) ent #17 identified the y intact and required ers. Resident #17 sustained	F	323				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E071	B. WINC	-		04/11/2012	
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		506	T ADDRESS, CITY, STATE, ZIP CODE THIRD PO BOX 338 BUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	resident #17 identified intact with unsteady be assistance of one stat transfers, and ambula sustained no falls sind prior assessment. Resident #17's 9/30/2 assessment) summar had a history of falls, and the environment hazards such as oxygetangled around his/het. Record review of resi assessment complete score of "10" indicating fall risk. Record review of resi assessment complete score of "18" indicating fall risk. Resident #17's 4/3/20 indicated the resident walker with supervision a wheel chair for long care plan indicated rerestorative therapy. Rursing care plan lack resident's current need mobility based on 12/ assessment.	terly MDS assessment for d the resident as cognitively balance and required limited ff member for bed mobility, ation. Resident #17 be admission or since the control of the complete the control of the	F3	323			

NAME OF PROVIDER OR SUPPLIER GREELEY COUNTY HOSPITAL LTCU SUMMARY STATEMENT OF DEFICIENCIES FRETTY AND SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC DENTIFYING MERCHANION) F 323 Continued From page 15 indicated resident #17 attempted to get out of bed without assistance and fell. The resident sustained a laceration to his/her felt eyebrow. Staff transported resident #17 to the emergency room on a cart at 915 fp. m. MST (Mountain Standard Time). Record review of the emergency room documentation for 3/12/2012 indicated the laceration above resident #17 self eyebrow measured 2.5 centimeters and the doctor repaired the laceration using Dermabond adhesive. During an observation on 4/4/2012 at 8.50 a.m. MST (Mountain Standard Time), direct care staff K and L assisted resident #17 out of bed and to the bathroom. Resident #17 out of bed and to the bathroom Resident #17 out of bed and to the bathroom Resident #17 out of bed and to the bathroom Resident #17 recalled he/she slipped off the edge of his/her bed and hit his/her head on the bedside drawer last month. During an interview on 4/4/2012 at 2:10 p.m. MST, direct care staff N verified staff reminded resident #17 to the call light to get assistance in order to prevent falls and staff had not used any other interventions to prevent falls for resident #17. During an interview on 4/5/2012 at 10:00 a.m. MST, administrative nursing staff C verified that resident #17 recalled the resident #17 to the other standard plan interview on 4/5/2012 at 10:00 a.m. MST, administrative nursing staff C verified that resident #17 recalled the reside	STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING		(X3) DATE SURVEY COMPLETED	
Set THIRD POBOX 338 TRIBUNE, KS 67379			17E071	B. WIN	IG_		04/1	1/2012
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 15 indicated resident #17 attempted to get out of bed without assistance and fell. The resident sustained a laceration to his/her left eyebrow. Staff transported resident #17 to the emergency room on a cart at 9:15 p.m. MST (Mountain Standard Time). Record review of the emergency room documentation for 3/12/2012 indicated the laceration above resident #17 is left yebrow measured 2.5 centimeters and the doctor repaired the laceration using Dermabond adhesive. During an observation on 4/4/2012 at 8:50 a.m. MST (Mountain Standard Time), direct care staff K and L assisted resident #17 used his/her four wheeled walker, took short steps, and shuffled the left foot on the floor. During an interview on 4/5/2012 at 7:45 a.m. MST, resident #17 recalled he/she slipped off the edge of his/her bed and hit his/her head on the bedside drawer last month. During an interview on 4/4/2012 at 2:10 p.m. MST, direct care staff N verified staff reminded resident #17 to use the call light to get assistance in order to prevent falls and staff had not used any other interventions to prevent falls for resident #17. During an interview on 4/5/2012 at 10:00 a.m. MST, administrative nursing staff C verified that			си	_	5	506 THIRD PO BOX 338		
indicated resident #17 attempted to get out of bed without assistance and fell. The resident sustained a laceration to his/her left eyebrow. Staff transported resident #17 to the emergency room on a cart at 9:15 p.m. MST (Mountain Standard Time). Record review of the emergency room documentation for 3/12/2012 indicated the laceration above resident #17's left eyebrow measured 2.5 centimeters and the doctor repaired the laceration using Dermabond adhesive. During an observation on 4/4/2012 at 8:50 a.m. MST (Mountain Standard Time), direct care staff K and L assisted resident #17 out of bed and to the bathroom. Resident #17 used his/her four-wheeled walker, took short steps, and shuffled the left foot on the floor. During an interview on 4/5/2012 at 7:45 a.m. MST, resident #17 recalled he/she slipped off the edge of his/her bed and hit his/her head on the bedside drawer last month. During an interview on 4/4/2012 at 2:10 p.m. MST, direct care staff N verified staff reminded resident #17 to use the call light to get assistance in order to prevent falls and staff had not used any other interventions to prevent falls for resident #17. During an interview on 4/5/2012 at 10:00 a.m. MST, administrative nursing staff C verified that	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
lacked interventions to prevent falls.	F 323	indicated resident #17 without assistance an sustained a laceration Staff transported resid room on a cart at 9:18 Standard Time). Record review of the documentation for 3/1 laceration above resid measured 2.5 centime repaired the laceration adhesive. During an observation MST (Mountain Stand K and L assisted resid the bathroom. Reside wheeled walker, took the left foot on the floot During an interview of MST, resident #17 refedge of his/her bed a bedside drawer last m During an interview of MST, direct care staff resident #17 to use th in order to prevent fal any other intervention resident #17. During an interview of MST, administrative resident #17 had a high	7 attempted to get out of bed ad fell. The resident in to his/her left eyebrow. Ident #17 to the emergency 5 p.m. MST (Mountain) emergency room 12/2012 indicated the Ident #17's left eyebrow eters and the doctor in using Dermabond an on 4/4/2012 at 8:50 a.m. Ident #17 out of bed and to ent #17 used his/her fourshort steps, and shuffled for. an 4/5/2012 at 7:45 a.m. Idealed he/she slipped off the ind hit his/her head on the month. an 4/4/2012 at 2:10 p.m. and N verified staff reminded in eall light to get assistance is and staff had not used in the individual	F	323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		17E071	B. WING	3	04	/11/2012	
	COUNTY HOSPITAL L	тси		STREET ADDRESS, CITY, STATE, ZIP C 506 THIRD PO BOX 338 TRIBUNE, KS 67879	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	MST, administrative staff should evaluate interventions to prevented that all residents adrifor falls due to age, or changes in environmoccurred, staff shoul changes to the residimmediately. The facility failed to a plan in place to prevente facility identified resident sustained a	on 4/4/2012 at 5:15 p.m. nursing staff A indicated that e each fall and initiate ent future falls. Dicy and procedure indicated nitted to this facility had a risk diagnoses, medications, and nent. In the event that a fall d implement the necessary	F3	323			
	(Mountain Standard cans of Lysol disinfe label of "keep out of irritant" and a 13 our non-acid disinfectant warning label of "mathroat irritation" in the room. During an interview of Direct Care Staff R rusually remained loof failed to keep the poin the shower room of	/2/12 at 10:30 a.m. MST Time) revealed two 12 ounce ctant spray with a warning reach of children" and "eye nice spray bottle of 3M at bathroom cleaner with a y cause eye, skin, nose, and e unlocked south hall shower on 4/2/12 at 10:45 a.m. MST, eported the shower room eked and confirmed staff tentially hazardous chemicals but of access to residents.					

Facility ID: H036101

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E071	B. WIN		·		
	ROVIDER OR SUPPLIER	L		50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879	<u> </u>	1/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	unattended by staff, vopen on the south had chemicals found within o a full, 1 quart contacteaner with a warnin of children" o a 1/8 full, 3.17 qual acid free cleaner with irritant" and "keep out o a full, 17 ounce conducteaner with a warning lately of a full, 17 ounce contube with a warning lately warning label of "eyreach or children" of a 1/4 full, 20 ounce cleanser double strend a warning label of "eyreach or children" of a full, 17.7 ounce of furniture polish with the of reach of children of a 1/4 full, 48 fluid of Doctor carpet cleaner "keep out of reach of of a full, 23 ounce conwith a warning label of irritant, burns" and "keep out of reach of of a full, 19 ounce concleanser with a warning label of irritant, burns" and "keep out of reach of of a 3/4 full, 16.5 oundisinfectant and deod to "keep out of reach of a 1/2 full, 18 ounce of the soundisinfectant and deod to "keep out of reach of a 1/2 full, 18 ounce of the soundisinfectant and deod to "keep out of reach of a 1/2 full, 18 ounce of the soundisinfectant and deod to "keep out of reach of a 1/2 full, 18 ounce of the soundisinfectant and deod to "keep out of reach of a 1/2 full, 18 ounce of the soundisinfectant and deod to "keep out of reach of a 1/2 full, 18 ounce of the soundisinfectant and deod to "keep out of reach of a 1/2 full, 18 ounce of the soundisinfectant and deod to "keep out of reach of a 1/2 full, 18 ounce of the soundisinfectant and deod to "keep out of reach of a 1/2 full, 18 ounce of the soundisinfectant and deod to "keep out of reach of a 1/2 full, 18 ounce of the soundisinfectant and deod to "keep out of reach of a 1/2 full, 18 ounce of the soundisinfectant and deod to "keep out of reach of a 1/2 full, 18 ounce of the soundisinfectant and	vith the doorway propped Ilway with the following in easy reach: ainer of Crew toilet bowl g label to "keep out of reach rt container of Bath Mate a warning label of "eye t of reach of children" ntainer of Dymon Grease arning label of "keep out of ye irritant," and "skin irritant" ntainer of Ozone penetrating abel of "harmful vapors" and children" e container of Powder agth with chlorine bleach with re irritant" and "keep out of we warning label of "keep out of container of Rose Shineup ne warning label of "keep out runce container of Rug r with a warning label of children" ntainer of Power foam Bravo of "corrosive skin and eye eep out of reach of children" ntainer of Kaboom Foam ng label of "eye irritant" and children" ce container of Fall Misty 11 lorizer with a warning label	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ON	(X3) DATE SURVEY COMPLETED	
		17E071	B. WINC	;		04/11/2012	
	COUNTY HOSPITAL LT	cu		STREET ADDRESS, C 506 THIRD PO BO TRIBUNE, KS 6			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	ROVIDER'S PLAN OF CORRECT H CORRECTIVE ACTION SHOU -REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	spray with a warning irritant," "harmful if sw reach of children." During an interview of Administrative Nursing failed to keep resident potentially hazardous reach. The facility's 4/3/12 "I and Their Safe Use" [as] responsible to enchemicals in their area to have access to the Observations on 4/2/10:54 a.m. MST revestemperatures (the act room sink, the east kis south hallway sink) but 124.5 degrees F. Furesidents #29, #2, #1 between 2:08 p.m. to water temperatures but and 128.0 degrees F. During an interview of Housekeeping/Maintereported maintenance resident rooms and contemperatures weekly Staff S reported a lact calibrate the dial them.	e container of Glass Betco label of "skin and eye vallowed" and "keep out of on 4/2/12 at 1:15 p.m. MST, ag Staff B confirmed staff ats safe by not securing a chemicals out of residents' Housekeeping Chemicals policy instructed "all staff as and will not allow patients a bottles of chemicals." 12 between 10:32 a.m. and aled common sink water tivity area sink, the shower atchenette sink, and the etween 121.6 degrees F and of ther observations in 7, #23, #18, and #6's rooms 3:27 p.m. MST revealed between 123.9 degrees F 11 at 1:37 p.m., enance/Laundry Staff S as staff randomly checked ommon sinks water with a dial thermometer. It is a staff and the staff of awareness of how to	F3	23			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E071	B. WIN		·		
	COUNTY HOSPITAL LT			50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879	04/1	1/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	degrees F and the other reached 112.0 degree usually used the lower with a blue sleeve for resident room water to Review of the facility' temperature checks of 3/29/12 that common water temperatures of degrees F and 118.0 During an interview of Housekeeping/Mainter reported he/she check temperature which returned the red sleeved, dial to Housekeeping/Mainter reported he/she recal and noted the activity reached 124.0 degree interview. Staff S corkeep water temperature to degrees F. The facility failed to environment remainer related to safe water #29, #2, #17, #23, #1 common areas and foindependently mobile	eratures between two facility and noted one lue sleeve reached 104.0 her with a red sleeve es F. Staff S stated he/she er reading dial thermometer all random common and emperature checks. Is weekly random water evealed between 2/1/12 and sinks and random room eached between 111.0 degrees F. In 4/5/12 at 11:00 p.m. MST, enance/Laundry Staff S ked resident 29's water ached 124.0 degrees F with thermometer. In 4/5/12 at 8:57 a.m. MST, enance/Laundry Staff S librated the dial thermometer area water temperature es minutes prior to the offirmed the facility failed to the dial thermometer area water temperature es minutes prior to the offirmed the facility failed to the dial thermometer of a residents when staff stored area water temperatures at a safe range below	F	323			

Facility ID: H036101

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E071	B. WING		04/11/2012	
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	cu	506	T ADDRESS, CITY, STATE, ZIP CODE THIRD PO BOX 338 BUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION	
F 325 SS=G	UNLESS UNAVOIDA Based on a resident's assessment, the facil resident - (1) Maintains accepta status, such as body unless the resident's demonstrates that thi	s comprehensive ity must ensure that a able parameters of nutritional weight and protein levels, clinical condition	F 325			
	by: The facility reported with 12 residents san one resident with nut Based on observation review, the facility fail sampled resident ma parameters of nutritio experienced a severe one month period and 3 month period. The implement interventic loss. Findings included: - The signed Physic for resident #9 includ mellitus, vascular der syndrome, Alzheimer	n, interview and record led to ensure that one intained acceptable inal status. Resident #9 e weight loss of 6.6% over a d an 8.2% weight loss over a facility failed to assess and ins to address the weight ian Orders dated 3/1/2012 ed diagnoses of diabetes				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E071	B. WIN	G		04/1	1/2012
	COUNTY HOSPITAL LT	си	•	5	REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 FRIBUNE, KS 67879	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325	urine retention. The 12/25/2011 Quarset) assessment for resident as rarely or r#9's functional status dependence on the a hygiene and eating. If food in his/her mouth weight loss, consume had mouth pain or diff Resident #9's height Resident #9's 6/25/20 assessment) summar indicated he/she need assistance with meals. Resident #9's 4/4/201 indicated he/she need monitored, may need diet, and had a goal of Resident #9's care pla of 149.5 pounds on 1.2/19/2012, and 137 p The care plan lacked interventions related to r loss. The care plan calorie diet, however, goals or interventions Dietary Consultant J '1/19/12 revealed resid weight loss of 4 pounds.	terly MDS (minimum data esident #9 identified the never understood. Resident revealed a total sistance of one for oral Resident #9 tended to hold adid not have a reported data therapeutic diet, and ficulty with chewing. Measured 59 inches. 111 CAAs (care area by for nutritional status ded soft foods and status ded to have weight to have a reduced calorie of no significant weight gain. In an also included the weights (8/2012, 145.5 pounds on ounds as the current weight. Specific goals or so the resident's weight gain a mentioned a reduced did not include specific to achieve these goals. In sprogress notes on dent #9 had a " significant dis in one week" and hange in [the resident's] progress note also	F	325			

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		1, ,			(X3) DATE SURVEY COMPLETED		
	17E071	B. WIN	G		04/1	1/2012	
	си		5	06 THIRD PO BOX 338			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	1		(EACH CORRECTIVE ACTION SHOUL	.D BE	(X5) COMPLETION DATE	
A nutritional assessm staff H on 3/26/12 ide pounds in 90 days with pound. The assessm had a food intake of 5 snacks twice daily. Record review of Phyrevealed resident #9 I supplements ordered calorie diabetic diet. The evidence of orders for Record review of resident grams per deciliter on 6.4-8.2 g/dL) and an a (normal 3.4-5.0 g/dL). Resident #9 I s weekl following weights: * 12/25/11 147 lbs.(price to 1/10/1/12 146.5 lbs. * 01/08/12 149.5 lbs. * 01/22/12 147 lbs. * 01/29/12 146 lbs. * 01/29/12 146 lbs. * 02/12/12 141.5 lbs. * 03/14/12 138 lbs. * 03/18/12 138 lbs. * 03/18/12 138 lbs. * 03/25/12 135 lbs. * Calculation of resident.	ent completed by dietary ntified a weight loss of 12 th a current weight of 135 ent also stated the resident 62% of meals and received sician orders dated 3/1/2012 had no nutritional and consumed an 1800 The Physician orders lacked or a planned weight loss. dent #9 's laboratory tests had a total protein of 6.5 in 10/4/11 (normal range halbumin level of 3.4 g/dL y weight record revealed the counds)	F	325				
	(11111111111111111111111111111111111111						
	COUNTY HOSPITAL LT SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page A nutritional assessm staff H on 3/26/12 ide pounds in 90 days with pound. The assessm had a food intake of 5 snacks twice daily. Record review of Phyrevealed resident #9 I supplements ordered calorie diabetic diet. The evidence of orders for Record review of resignation provided the resident grams per deciliter on 6.4-8.2 g/dL) and an a (normal 3.4-5.0 g/dL). Resident #9 I s week I following weights: * 12/25/11 147 lbs.(provided to 1/20/12 146.5 lbs. * 01/01/12 146.5 lbs. * 01/01/12 145.5 lbs. * 01/29/12 146 lbs. * 02/05/12 150 lbs. * 02/12/12 146 lbs. * 02/12/12 146 lbs. * 02/12/12 146 lbs. * 02/12/12 146.5 lbs. * 02/12/12 146.5 lbs. * 03/14/12 138 lbs. * 03/18/12 138 lbs. * 03/18/12 138 lbs. * 03/25/12 135 lbs. Calculation of resident countries and contributed to the contributed to	COUNTY HOSPITAL LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 A nutritional assessment completed by dietary staff H on 3/26/12 identified a weight loss of 12 pounds in 90 days with a current weight of 135 pound. The assessment also stated the resident had a food intake of 52% of meals and received snacks twice daily. Record review of Physician orders dated 3/1/2012 revealed resident #9 had no nutritional supplements ordered and consumed an 1800 calorie diabetic diet. The Physician orders lacked evidence of orders for a planned weight loss. Record review of resident #9 's laboratory tests indicated the resident had a total protein of 6.5 grams per deciliter on 10/4/11 (normal range 6.4-8.2 g/dL) and an albumin level of 3.4 g/dL (normal 3.4-5.0 g/dL). Resident #9 's weekly weight record revealed the following weights: * 12/25/11 147 lbs.(pounds) * 01/01/12 146.5 lbs. * 01/129/12 145.5 lbs. * 01/129/12 146 lbs. * 02/12/12 146 lbs. * 02/12/12 146 lbs. * 02/12/12 145.5 lbs. * 02/12/12 146.5 lbs. * 03/04/12 141.5 lbs. * 03/04/12 141.5 lbs. * 03/04/12 145.5 lbs. * 03/04/12 145.5 lbs. * 03/04/12 141.5 lbs. * 03/04/12 138 lbs. * 03/11/12 138 lbs. * 03/18/12 138 lbs.	COUNTY HOSPITAL LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 A nutritional assessment completed by dietary staff H on 3/26/12 identified a weight loss of 12 pounds in 90 days with a current weight of 135 pound. The assessment also stated the resident had a food intake of 52% of meals and received snacks twice daily. Record review of Physician orders dated 3/1/2012 revealed resident #9 had no nutritional supplements ordered and consumed an 1800 calorie diabetic diet. 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Calculation of resident #9 's weight loss revealed	COUNTY HOSPITAL LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 A nutritional assessment completed by dietary staff H on 3/26/12 identified a weight loss of 12 pounds in 90 days with a current weight of 135 pound. The assessment also stated the resident had a food intake of 52% of meals and received snacks twice daily. Record review of Physician orders dated 3/1/2012 revealed resident #9 had no nutritional supplements ordered and consumed an 1800 calorie diabetic diet. The Physician orders lacked evidence of orders for a planned weight loss. Record review of resident #9 's laboratory tests indicated the resident had a total protein of 6.5 grams per deciliter on 10/4/11 (normal range 6.4-8.2 g/dL) and an albumin level of 3.4 g/dL (normal 3.4-5.0 g/dL). Resident #9 's weekly weight record revealed the following weights: * 12/25/11 147 lbs.(pounds) * 01/08/12 149.5 lbs. * 01/105/12 145.5 lbs. * 01/122/12 147 lbs. * 01/29/12 146 lbs. * 02/105/12 145 lbs. * 02/105/12 145.5 lbs. * 02/105/12 145.5 lbs. * 02/105/12 145.5 lbs. * 02/105/12 145.5 lbs. * 03/14/12 138 lbs. * 03/18/12 138 lbs. * 03/18/12 138 lbs. Calculation of resident #9 's weight loss revealed	COUNTY HOSPITAL LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 A nutritional assessment completed by dietary staff H on 3/26/12 identified a weight loss of 12 pounds in 90 days with a current weight of 135 pound. The assessment also stated the resident had a food intake of 52% of meals and received snacks twice daily. Record review of Physician orders dated 3/1/2012 revealed resident had a total protein of 6.5 grams per deciliter on 10/4/11 (normal range 6.4-8.2 g/dL), and an albumin level of 3.4 g/dL (normal 3.4-5.0 g/dL), and an albumin level of 3.4 g/dL (normal 3.4-5.0 g/dL). Resident #9 's weekly weight record revealed the following weights: 1 2/25/11 147 lbs. (pounds) 1 1/20/12 146.5 lbs. 1 0/10/12/12 146.5 lbs. 1 0/10/21/12 146.5 lbs. 2 0/10/21/2 144.5 lbs. 2 0/21/21/2 146 lbs. 2 0/21/21/2 146 lbs. 2 0/21/21/2 146 lbs. 3 0/31/41/2 138 lbs. 3 0/31/31/2 138 lbs. 3 0/31/31/2 138 lbs. 3 0/31/31/2 138 lbs. Calculation of resident #9's weight loss revealed	CONTRECTION TREOT1 STREET ADDRESS, CITY, STATE, ZIP CODE SOS THIRD PO BOX 338 TRIBUTE, KS 67879	

Facility ID: H036101

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E071	B. WIN	G		04/1	1/2012	
	COVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 325	to 03/25/12 (135 lbs.) loss. The resident ha from 12/27/11 to 3/25 weight loss. During an observation MST (Mountain Stand received assistance was small bites of egg, chaminutes, and required continue eating without the mashed potatoes and for several minutes and to continue eating with During an interview of MST, administrative mashed potatoes and for several minutes and to continue eating with During an interview of MST, administrative mashed potatoes and for several minutes and to continue eating with During an interview of MST, administrative mashed potatoes and for several minutes and to continue eating with During an interview of MST, administrative mashed potatoes and for several minutes and to continue eating with During an interview of MST, dietary staff H was weighen the significant staff reported he/she weight, but only calcumentation weight loss quarterly, verified he/she comploof resident #9's care preflect the resident's contain the intervention weight loss.	of 9.5 lbs., a 6.6% weight d a 3 month weight loss /12 of 12 lbs, an 8.2% n on 4/4/2012 at 10:00 a.m. dard Time), resident #9 with eating breakfast, took ewed each bite for several dencouragement to ut offering substitutes. n on 4/4/2012 at 12:00 p.m. eived assistance with eating sof turkey with gravy, I spinach, chewed each bite and required encouragement thout offering substitutes. n 4/4/2012 at 5:15 p.m.	F	325				

17E071 B. WING	04/11/2012
NAME OF PROVIDER OR SUPPLIER GREELEY COUNTY HOSPITAL LTCU STREET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 TRIBUNE, KS 67879	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 325 Continued From page 24 MST, consultant staff J verified that he/she came monthly, reviewed resident #9's medical record, and consulted with staff regarding the resident's nutritional condition and needs. Dietary staff J further verified that during his/her review of resident #9's information on 3/15/2012, he/she may not have considered that resident #9 had a significant weight loss considering the resident remained above his/her ideal body weight of 98 pounds. Based on the weights recorded from 2/5/2012 to 3/25/2012 which indicated a steady weight loss, resident #9 should have received a supplement to support his/her nutritional needs. The facility failed to ensure that one sampled resident maintained acceptable parameters of nutritional status. Resident #9 experienced a severe weight loss of 6.6% over a one month period. The facility failed to implement effective interventions to address resident #9' s weight loss and the resident continued to lose weight. The clinical record lacked evidence to show this weight loss and the resident continued to lose weight. The clinical record lacked evidence to show this weight loss as unavoidable. F 329 483.25(1) DRUG REGIMEN IS FREE FROM publical resident should be reduced to discontinued; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		17E071	B. WIN	G_		04/1	1/2012
	COUNTY HOSPITAL LT	си		5	REET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 TRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 329	who have not used ar given these drugs unl therapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral interventio	nust ensure that residents ntipsychotic drugs are not ess antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic dose reductions, and	F	329			
	by: The facility reported a with 10 residents sam medication review. Based on observation review, the facility fail 10 residents sampled (drugs used without a the facility failed to me effects and adverse rebox warnings (#15, 21 and 17). - Resident #15's 2/29 included diagnoses of hypokalemia, hypoma failure exacerbation, with left face/arm/leg insufficiency, restless	a, interview, and record ed to ensure that 10 of the for unnecessary drugs dequate monitoring) when conitor for potential side eactions as related to black 7, 10, 20, 12, 16, 26, 18, 2, 0/12 physician's orders of acute gastroenteritis, egnesia, congestive heart cerebrovascular accident paralysis, renal leg syndrome, atrial type 2 diabetes mellitus,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	DINC		(X3) DATE SUR COMPLETE	
		17E071	B. WIN	G		04/1 ⁻	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		5	REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 FRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 329	arthritis. The 2/29/12 an order for Seroquel medication) 25 mg (mevening for agitation. Resident #15's 1/22/1 Data Set) Assessmer impaired cognition, mantipsychotic and antipsychotic antipsychotic antipsychotic antipsychotic and antipsychotic an	n, and degenerative knee physician's orders included (an antipsychotic nilligrams) by mouth every 2 Quarterly MDS (Minimum of reported moderately ild depression, and received idepressant medications. 1 care plan failed to received Seroquel or Warning. Arx.com, Seroquel d mortality in elderly a related psychosis greater 12 1:14 p.m. MST (Mountain aled resident #15 sat in a a call light within reach, and his/her legs remained er foot rest. n 4/5/12 at 8:31 a.m. MST, g Staff C confirmed the lack Box Warnings to the	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E071	B. WIN	G		04/1	1/2012
	COUNTY HOSPITAL LT	си	•	50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	- Resident #27's 3/9/included diagnoses of atrial fibrillation, hypothypercholesterolemia without behavioral disdisorder, glaucoma, harteriosclerosis, osteoregion, and a pacema orders renewed order medication) 200 mg (and Acetaminophen (medication) 500 mg b 650 mg by mouth everpain. Resident #27's 3/23/12 Data Set) Assessmer cognition and the resist special category of mace and the resist special categ	12 physician's orders f congestive heart failure, thyroidism, , hypopotassemia, dementia turbances, depressive ypertension, coronary barthrosis of pelvic and thigh taker. The 3/9/12 physician's is for Amiodorone (a heart milligrams) by mouth daily a pain and fever by mouth at breakfast and bry four hours as needed for 2 Annual MDS I(Minimum that reported severely impaired dent did not receive a edications. 2 lacked mention of black bodorone or Acetaminophen. 3 lacked mention of black bodorone or Acetaminophen. 4 lacked mention of black bodorone or Acetaminophen. 5 lacked mention of black bodorone or Acetaminophen. 6 lacked mention of black bodorone or Acetaminophen. 6 lacked mention of black bodorone or Acetaminophen. 7 lacked mention of black bodorone or Acetaminophen. 8 lacked mention of black bodorone or Acetaminophen.	F	329			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		17E071	B. WIN	G		04/1	1/2012
	COUNTY HOSPITAL LT	си		5	REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 FRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	being added to the lal products that contain Observations on 4/4/² (Mountain Standard Tambulated independent steady gait. During an interview of Licensed Nursing Stamus Harris Care plan lacked the black box warning Acetaminophen. The facility failed to expression as related to Amiodorone and Acetaminodorone and Acetaminod	ning, itching, or rash) [were] pel of all prescription drug acetaminophen." IZ 11:05 a.m. MST Time) revealed resident #27 potly in his/her room with a In 4/4/12 at 3:23 p.m. MST, Iff B confirmed resident ad mention or the content of a for Amiodorone or Insure resident #27 did not adrugs (drugs used without when the facility failed to side effects and adverse be black box warnings for framinophen. Issicians order sheet listed the so of dominant side the sion, depressive disorder, besity, anxiety state, thyroidism and constipation. The sicians order and constipation. The sicians order sheet also included an order mcg (micrograms) to be St. I Quarterly MDS I the resident had a	F	329			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		PLE CONSTRUCTION G	(X3) DATE SUF	
		17E071	B. WIN	G		04/1	1/2012
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		5	REET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 FRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	black box warnings. According to blackbox medication contained Fentanyl: "This produconcentration of a poragonist, fentanyl. Schave the highest pote associated risk of fata respiratory depression. Review of resident #1 Regimen Review for the finformation related. On 4/4/12 at 6:35 a.m. time, direct care staff. #10 with morning care signs of depression of during cares. An interview with licer 8:30 a.m. MST confirmedications with blackbeen included in the replans. The facility failed to perform the proportion of the facility failed to perform the facil	e effects or adverse e of medications which had exx.com the following black box warnings: act contains a high tent Schedule 2 opioid nedule 2 opioid substances intial for abuse and all overdose due to n." O's monthly Medication the past year revealed a lack to black box warnings. I. (MST) mountain standard L and R assisted resident es. The resident had no r inappropriate behaviors ased staff C on 4/4/12 at med that monitoring for k box warnings had not residents' nursing care rovide adequate monitoring ests and adverse reactions to V. Resident #10 received a had a BBW.	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION 3	(X3) DATE SUF COMPLET	
		17E071	B. WIN	G		04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си	•	5	REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 FRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	and osteoarthrosis. Talso had an order for at hour of sleep. Resident #20's 12/26. Data Set) assessment intact cognition, no intreceived antidepressa. The resident's 12/21/information related to depression, however, information related to Seroquel which had a According to blackbook this BBW, "Elderly papsychosis treated with drugs are at an increate to placebo" and "close thinking or unusual characteristic MST (Mountain Standat the dining room tabresident had no inappet the meal. An interview on 4/4/12 licensed staff C reveal care plan did not inclumedications that had During an interview of administrative nurse A	che physician's order sheet Seroquel 25 mg (milligram) In quarterly MDS (Minimum trevealed the resident had appropriate behaviors, and ant medications. In nursing care plan had the resident's diagnosis of the care plan lacked any the resident's use of BBW (Black Box Warning). In attribute the seroquel contained tients with dementia related in atypical antipsychotic ased risk of death compared to observation for suicidal manges in behavior." In on 4/4/12 at 11:30 a.m. dard Time), resident #20 sat ole after eating a meal. The propriate behaviors during In at 2:34pm MST with alled resident #20's nursing and information related to BBWs. In 4/4/12 at 3:30 p.m. MST, A confirmed the facility de information regarding	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		17E071	B. WIN	G		04/1	1/2012
	COUNTY HOSPITAL LT	си	•	5	REET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 FRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	Continued From page	31	F	329			
	receive unnecessary	nsure resident #20 did not drugs when staff failed to or potential side effects and related to a BBW for					
	following diagnoses of depression, parkinson degeneration, hyperte atherosclerosis, dysp airway obstruction, ar physicians order shee	n 's disease, macular ension, coronary epsia, vertigo, chronic nd osteoarthritis. The et also included an order for pressure medication) 25 mg					
	Data Set) Assessmer	11 Annual MDS (Minimum at and the 10/20/11 ted severely impaired					
	monitoring for side ef	Plan failed to mention any fects or adverse reactions cations which had black box					
	withdrawn abruptly (p coronary artery disea	a black box warning: therapy should not be articularly in patients with se) but gradually tapered bid acute tachycardia,					
	Regimen Review for t	12's monthly Medication the past year revealed a lack to black box warnings.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
		17E071	B. WING	3	04	/11/2012
	OVIDER OR SUPPLIER	тси		STREET ADDRESS, CITY, STATE, ZIP (506 THIRD PO BOX 338 TRIBUNE, KS 67879	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 329	and R assisted resident steady gait noted. An interview with lice 8:30 a.m. MST conference medications with bladen included in the plans. During an interview consultant E reported the need for black be He/she reported the record currently ident BBWs, but had not into the nursing care. The facility failed to receive unnecessar adequately monitor adverse reactions a Warnings for Toprologous Persident #16's 3/4 included diagnoses hypothyroidism, hypothyroidi	ensed staff C on 4/4/12 at irred that monitoring for ack box warnings had not e residents' nursing care on 4/5/12 at 10:55 a.m. MST ad recently becoming aware of example on a care plans. The endication administration and incorporated the information explans. ensure resident # 12 did not by drugs when staff failed to for potential side effects and so related to Black Box and so related to B	F3	329		
	cerebral atheroscler insomnia. The phys order for Seroquel 2 sleep. Resident #16's 1/29 data set) assessme	estive heart failure, dyspepsia, rosis, osteoarthosis, and sician order sheet included an 25 mg (milligrams) at hour of 1/12 quarterly MDS (minimum nt revealed the resident had received antipsychotic and				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		DNSTRUCTION	(X3) DATE SUI COMPLET	
		17E071	B. WING			04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		506 TH	NDDRESS, CITY, STATE, ZIP CODE IRD PO BOX 338 INE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	information related to however, lacked any potential side effects related to the use of S (Black Box Warning). According to blackbox this BBW, "Elderly papsychosis treated with drugs are at an increate to placebo" and "close thinking or unusual characteristic placebox or unusual	ations. It nursing care plan included anxiety and depression, information regarding and adverse reactions. Seroquel which had a BBW arx.com, Seroquel contained tients with dementia related in atypical antipsychotic ased risk of death compared e observation for suicidal hanges in behavior," In on 4/3/12 at 3:00 p.m. dard Time), resident #16 way with a steady gait and tiens of depression or orders. It at 2:34 p.m. MST with alled resident #16's nursing ude information related to BBWs. In 4/4/12 at 3:30 p.m. MST, A confirmed the facility de information regarding is nursing care plans. Insure resident #16 did not drugs when staff failed to or potential side effects and	F3	29			

AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E071	B. WIN	G		04/1	1/2012
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879	, , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
	failure, anemia, sleep depressive disorder, of diseases and abnorm other specified hemip affecting unspecified essential hypertension of unspecified type of ischemia, late effects constipation, hemorrh pain in joint involving muscle weakness, os giddiness, insomnia, vincontinence, history system not elsewhere Resident #2's signed 2/1/2012 included an milligrams. The 2/24/2012 Quarte set) assessment for rewith severely impaired behaviors, no reporte pain received pain mereceived pain mereceived pain mereceived pain direction to staff relate which had a BBW (Bl. According to blackbox (Tylenol) had the potential potentia	ed diagnoses of tion, congestive heart arousal disorder, other extrapyramidal al movement disorders, legia and hemiparesis side, tear film insufficiency, n, coronary atherosclerosis vessel, transient cerebral of cerebrovascular disease, lage of gastrointestinal tract, multiple sites, general teoporosis, dizziness and weight loss, diarrhea, urinary of diseases of circulatory e classified. Physician Orders dated order for Tylenol 500 erly MDS (minimum data esident #2 identified him/her d cognition, no reported d falls, and reported mild edication. 2 nursing care plan lacked ed to the use of Tylenol	F	3329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		NSTRUCTION	(X3) DATE SU COMPLET	
		17E071	B. WING	§		04/1	1/2012
	COUNTY HOSPITAL L	тси		506 THIF	DDRESS, CITY, STATE, ZIP CODE RD PO BOX 338 NE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	his/her wheel chair, signs of pain or districtions of pain or districtions of pain or districtions are painted to the transformation related to the transformation for potential reactions as related and the transformation of the tran	cod in his/her room, in front of alert, sorting papers, without ess noted. On 4/4/2012 at 5:15 p.m. MST Time), administrative nursing esident #2's care plan lacked to the Black Box Warning for ensure resident #2 did not a drugs (drugs used without a) when the facility failed to side effects and adverse to BBWs for Tylenol. Itian Orders dated 3/1/2012 added diagnoses of adult addration, hypothyroidism, a vitamin D deficiency, a vitamin D deficiency, a constipation, neurogenic sis, insomnia, edema, history s and embolism, long term	F	329			

PRINTED: 04/17/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E071	B. WIN	IG		04/1	1/2012	
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	си	1	5	REET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 TRIBUNE, KS 67879	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 329	Resident #17's 4/3/20 direction to staff related Tylenol, Remeron, and BBWs (Black Box Was According to blackbox medications contained of Fluoxetine: patients the potential for clinicumusual changes in boto Tylenol: Acetamino potential for causing sthe potential for causing step of the fact difficulty breathing, it concentrates to Remeron: patients stafficulty breathing, and country the worsening, suicidality behavior. To Coumadin: Coumac potential to cause material to cause	tion and an antidepressant. 212 nursing care plan lacked ed to the use of Fluoxetine, d Coumadin which all had arnings). 22 carx.com, the following d BBWs: 23 started on Fluoxetine had al worsening, suicidality, or ehavior. 24 phen (Tylenol) had the severe liver injury and had ang allergic reactions such the mouth, and throat, thing or a rash. 25 started on Remeron the potential for clinical the potential for clinical the potential for clinical the potential bleeding at the land with higher doses NR (International the on 4/4/2012 at 8:50 a.m. that Time), direct care staff dent #17 out of bed and to cont #17 had no signs or distress noted during on. Resident remained calm	F	329				

Facility ID: H036101

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING		(X3) DATE SURVEY COMPLETED		
		17E071	B. WIN	IG_		04/1	1/2012	
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		5	REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 FRIBUNE, KS 67879			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 329	and Coumadin (Warfa The facility failed to endication with BBW According to www.bla medication contained Accetaminophen: "In a highlighting the poten and a Warning highlig allergic reactions (e.g.	In Remeron (Mirtazapine), arin). Insure resident #17 did not drugs (drugs used without when the facility failed to ide effects and adverse of BBWs for Fluoxetine, d Coumadin. In physicians order sheet all failure to thrive, anxiety efficiency, coronary ery bypass graft, urinary rethrosis, epistaxis, urinary regies. Physician order sheet Tylenol, Lasix, Atenolol, and Minimal Data Set on dent #26 had severely gnition and received by. In the same plan revealed the etion to staff regarding and adverse reaction of (black box warning). In the same plan is the following black box warnings: addition, a Boxed Warning tial for severe liver injury shting the potential for, swelling of the face, ficulty breathing, itching, or	F	329				
	, 3							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER	17E071				04/1	1/2012
	COUNTY HOSPITAL LT	cu		50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	given in excessive an profound diuresis with depletion. Therefore is required, and dose adjusted to the individ DOSAGE AND ADMI Atenolol: "Beta-block withdrawn abruptly be acute tachycardia, hy ischemia". Coumadin: "May cau. On 4/4/12 at 7:50 a.m. time) direct care staff 26 with activities of diremained calm and componential side effects black box medication. The facility failed to profor potential side effects black box medications. The facility failed to profor potential side effects black asix, Atenolol, Coumbands. - Resident #18's 3/9/listed diagnosis of chedisease, chronic pulnacquired hypothyroid iron deficiency anemical	ducts that contain a potent diuretic which, if nounts, may lead to n water and electrolyte , careful medical supervision and dose schedule must be dual patient 's needs (see INISTRATION)." Ker therapy should not be at gradually tapered to avoid repertension, and/or ase major or fatal bleeding." a. MST (mountain standard a K and M assisted resident # aily living. The resident cooperative with cares. an 4/4/12 at 12:30 p.m. MST be confirmed resident #26's ked information regarding and adverse reactions of s. arovide adequate monitoring cts and adverse reactions to by. Resident # 26 received anadin and Tylenol which had al 20 physicians order sheet ronic ischemic heart	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E071	B. WIN	G		04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	CU		50	EET ADDRESS, CITY, STATE, ZIP CODE 6 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	esophagitis, urinary franticoagulants, insomosteoarthrosis. The plisted orders for Tylen Atenolol, and Coumac The Admission MDS 11/23/11 and the Quassessments for resident had moderat behaviors, and receiv Residents #18's care direction to staff regal and adverse reaction lasix, cuprimine, atendad BBWs (Black Box According to www.blamedication contained Acetaminophen: "In a highlighting the poten and a Warning highligallergic reactions (e.g mouth, and throat, diffrash) are being added prescription drug product acetaminophen". Lasix: "This agent is a given in excessive amprofound diuresis with depletion. Therefore, is required, and dose	congestive heart failure, equency, long- term use of mia, calculus of kidney, and obysician order sheet also ol, Lasix, Cuprimine, din. (Minimal Data Set) on interly MDS on 1/3/12 lent #18 indicated the ely impaired cognition, no ed antidepressants. plan on 4/3/12 lacked rding potential side effects related to acetaminophen, colol and coumadin, which warning). ackboxrx.com the following black box warnings: addition, a Boxed Warning tial for severe liver injury enting the potential for, swelling of the face, ficulty breathing, itching, or it to the label of all ducts that contain a potent diuretic which, if mounts, may lead to a water and electrolyte careful medical supervision and dose schedule must be lual patients needs (see NISTRATION)." Ins planning to use	F	329			

N NUMBER:	,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
'E071 B. W	VING		04/1′	1/2012
	500	S THIRD PO BOX 338		
D BY FULL PRI	EFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
sage ts. sually. under the cients ny d not be ed to avoid or bleeding." 2 at 4:15 vealed an resident. p.m. MST t # 18's potential medications monitoring reactions to received enolol and DCOCCAL procedures ization, arding the				
	SAGE STED BY FULL ORMATION) PROTES TO BY FULL ORMATION) PROTES TO BY FULL ORMATION) PROTES TO BY FULL ORMATION PROTES TO BY FULL ORMATION	PEOT1 STRE 506 TR STR 506 TR STRE 506 TR STRE 506 TR STRE 506 TR STRE 506 TR STR 506 TR STRE 506 TR STRE 506 TR STRE 506 TR STRE 506 TR STR	A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE SOE THIRD PO BOX 338 TRIBUNE, KS 67879 ENCIES D BY FULL ORMATION) F 329 sage its. Issually. F under the litents iny d not be eed to avoid or bleeding." 2 at 4:15 Ivealed an resident. I p.m. MST It # 18's I potential medications monitoring reactions to ir received encolol and DCOCCAL F 334 Procedures itization, arding the	A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 TRIBUNE, KS 67879 ENCIES D BY FULL ORMATION) F 329 sage its. Issually. In under the litents In y d not be red to avoid or bleeding." 2 at 4:15 vealed an resident. Ip.m. MST at # 18's ip potential medications monitoring reactions to a received enclol and DCOCCAL F 334 PREETX ABUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 TRIBUNE, KS 67879 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329 sage its. In the APPROPRIATE DEFICIENCY F 334 F 334 COMPLETE OA4/1: STREET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 TRIBUNE, KS 67879 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329 sage its. In the APPROPRIATE DEFICIENCY F 334 F 334 F 334 F 329 STRIBUNE, KS 67879 PREETX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 334 F 329 SAGE THIRD PO SO THE APPROPRIATE DEFICIENCY F 334 F 334 F 329 SAGE THEORY F 334 F 329 SAGE THEORY F 334 F 340 F 334 F 340 F 334 F 340 F 334 F 340 F 341 F 341 F 341 F 341 F 342 F 344 F 345 F 346 F 346 F 346 F 347 F 34

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUIL				
		17E071	B. WIN	G		04/1	1/2012
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	cu		50	EET ADDRESS, CITY, STATE, ZIP CODE 16 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 334	contraindicated or the immunized during this (iii) The resident or the representative has the immunization; and (iv) The resident's medocumentation that in following: (A) That the resident representative was puthe benefits and pote immunization; and (B) That the resident influenza immunization influenza immunization. The facility must deverthat ensure that (i) Before offering the immunization, each relegal representative resident is on immunization; (ii) Each resident is on immunization, unless medically contraindical already been immunicial in the representative has the immunization; and (iv) The resident's medical in the resident in the resident's medical in the resident in the resident's medical in the resident in the resident in the resident's medical in the resident in the resi	ffered an influenza or 1 through March 31 mmunization is medically eresident has already been is time period; he resident's legal eresident's legal eroportunity to refuse edical record includes indicates, at a minimum, the or resident's legal rovided education regarding intial side effects of influenza effects of influenza effects. The provided education regarding intial side effects of influenza effects of influenza effects of influenza effects of the end or did not receive the end due to medical effects. The provided education regarding intial side effects of the effered a pneumococcal esident, or the resident's eccives education regarding intial side effects of the effered a pneumococcal the immunization is eated or the resident has every effect or the resident has every effect of includes edical record includes edical record includes indicated, at a minimum, the	F	334			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E071	B. WIN	IG		04/1	1/2012
	COUNTY HOSPITAL LT	си	•	5	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 334	the benefits and pote pneumococcal immur (B) That the residen pneumococcal immur the pneumococcal imcontraindication or re (v) As an alternative, and practitioner recorpneumococcal immur years following the fir immunization, unless	rovided education regarding ntial side effects of nization; and t either received the nization or did not receive munization due to medical fusal. based on an assessment mmendation, a second nization may be given after 5 st pneumococcal medically contraindicated or sident's legal representative	F	334			
	by: The facility reported. The sample included Based on interview are failed to provide 5 of residents' legal representation on influent and potential side effect (Residents #14, #13, Findings included: - Review of the information administrative nursing records of 5 sampled	nd record review the facility 5 residents and/or the esentatives with educational eza, including the benefits ects of the immunization. #19, #22, and #4) mation provided by g staff C from the clinical residents revealed the as related to influenza and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E071	B. WIN			04/4	4/0040
	ROVIDER OR SUPPLIER		ı	50	EET ADDRESS, CITY, STATE, ZIP CODE 6 THIRD PO BOX 338 RIBUNE, KS 67879	04/1	1/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 334	immunization prior to received the influenz 10/14/2011. Although of attorney) signed the form, the clinical recoresident and/or DPO. information related to side effects of the value Resident #13: refuse immunization prior to received the influenz 10/14/2011. Although of attorney) signed the form, the clinical recoresident and/or DPO. information related to side effects of the value Resident #19: receive immunization prior to received the influenz 10/14/2011. Although of attorney) signed the form, the clinical recoresident and/or DPO. information related to side effects of the value Resident #22: receive immunization prior to received the influenz 10/14/2011. Although of attorney) signed the form, the clinical recoresident and/or DPO. information prior to received the influenz 10/14/2011. Although of attorney) signed the form, the clinical recoresident and/or DPO.	ed the pneumococcal this 12 month review and a immunization on the DPOA (durable power the immunization consent ord lacked evidence the A received educational to the benefits and potential occine. In the DPOA (durable power the immunization on the DPOA (durable power the immunization consent ord lacked evidence the A received educational to the benefits and potential occine. In the DPOA (durable power the immunization consent ord lacked evidence the A received educational to the benefits and potential occine. In the DPOA (durable power the immunization on the DPOA (durable power the immunization consent ord lacked evidence the A received educational to the benefits and potential ord lacked evidence the A received educational to the benefits and potential ord the pneumococcal	F	334			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E071	B. WING _		04/11/2012	
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 TRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 334	received the influenza 10/14/2011. Although of attorney) signed the form, the clinical recoresident and/or DPO/ information related to side effects of the vactor of the v	the pneumococcal this 12 month review and a immunization on the DPOA (durable power e immunization consent rd lacked evidence the A received educational the benefits and potential ccine. In 4/3/2012 at 4:15 p.m. MST Time), administrative nursing either the residents nor the consistently received the on required for both the procecal immunizations the immunizations. In a disconsistently received the on required for both the procecal immunizations the immunizations the immunizations the resident who wanted an eceive education about the administration of it and the occumented in the resident's I rovide 5 of 5 residents the gal representatives with on on influenza and the benefits and potential	F 334			
F 356 SS=C	#13, #19, #22, and #4483.30(e) POSTED NINFORMATION	-	F 356	5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E071	B. WIN	G		04/1	1/2012
	COUNTY HOSPITAL L	тси	I	506 T	ADDRESS, CITY, STATE, ZIP CODE CHIRD PO BOX 338 SUNE, KS 67879	1 04/1	1/2012
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		OULD BE	(X5) COMPLETION DATE
F 356	by the following cate unlicensed nursing s resident care per shing a Registered nursing some cate of the cate of t	and the actual hours worked gories of licensed and staff directly responsible for ft: ses. cal nurses or licensed s defined under State law). aides. It the nurse staffing data a daily basis at the beginning nust be posted as follows: format. The readily accessible to see format. In the posted daily nurse of the public for to exceed the community serior to exceed the community. Intain the posted daily nurse nimum of 18 months, or as any, whichever is greater. This not met as evidenced a census of 25 residents. In interview, and recordicate interview.	F	356			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E071	B. WIN	G		04/1	1/2012
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		5	REET ADDRESS, CITY, STATE, ZIP CODE 106 THIRD PO BOX 338 TRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORI PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		LD BE	(X5) COMPLETION DATE
F 356	resident census maintain the posted of minimum of 18 month. Findings included: - Observations on 4/2 (Mountain Standard T board with nurse staff between the facility's Review of the dry erastaffing data lacked m worked for 7 of 9 staff licensed nursing staff shifts, and the current Observations on 4/3/2 revealed the dry erastinformation updated for shifts but lacked actual the titles of the day are and the current census.	aily nurse staffing data for a s. 2/12 at 10:41 a.m. MST time) revealed a dry erase ing information for 4/2/12 atrium and the east hallway. See board revealed nurse mention of the actual hours is listed, the titles of the on both of the 12 hour accensus. 12 at 9:19 a.m. MST the board with nurse staffing for 4/3/12 day and night all hours worked for all staff, and night licensed nurses, is.	F	356	,		
	Administrative Nursing awareness of the requipost such as the total hours worked by staff licensed nursing staff Licensed Practical Nurand to maintain the podata for a minimum of Although requested, to	n 4/5/12 at 9:12 a.m. MST, g Staff A reported a lack of uired nurse staffing data to number and the actual, the categories of the of Registered Nurse and urse, the resident census, osted daily nurse staffing f 18 months.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E071	B. WIN	G		04/11/2012	
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	cu		50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 356	Continued From page	e 47	F	356			
	number and the actual categories of the licer Registered Nurse and the resident census, a	ost on a daily basis the total al hours worked by staff, the nsed nursing staff of d Licensed Practical Nurse, and to maintain the posted ata for a minimum of 18					
F 363 SS=D	483.35(c) MENUS MI ADVANCE/FOLLOW	EET RES NEEDS/PREP IN ED	F	363			
	dietary allowances of Board of the National	e nutritional needs of ace with the recommended the Food and Nutrition Research Council, National s; be prepared in advance;					
	by: The facility reported	is not met as evidenced a census of 25 residents. itchen and one resident et.					
	review, the facility fail on a pureed diet rece nutritional needs of th with the recommende	n, interview, and record ed to ensure one resident ived foods that met the ne resident in accordance ed dietary allowances. The the recipes for pureed mpled resident.					
	Findings included:						
	(Mountain Standard 7	3/12 at 5:06 p.m. MST Fime) revealed Dietary Staff coop of beef stroganoff and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E071	B. WIN	3		04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL L	тси		506 T	ADDRESS, CITY, STATE, ZIP CODE CHIRD PO BOX 338 SUNE, KS 67879	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 363	from a can in the blee Observations on 4/3 revealed Dietary State bowl of tossed lettuce with his/her gloved his Dietary Staff T adde of tossed lettuce sala and an unmeasured juice into the blende During an interview of Dietary Staff H report a recipe for pureed to salad. At 5:41 p.m., recipe for pureed to salad. The salad salad indicated the facility vegetables and salad indicated the smalles 5 servings, the recipe of salad/prepared su 1/2 slices of bread, and or milk. During an interview of Staff H confirmed diregistered dietician as stroganoff and tosse	ount of lukewarm beef broth inder. /12 at 5:12 p.m. MST ff T scooped a small serving be salad into a clean blender hand. At 5:13 p.m. MST, indicated a day with his/her gloved hand amount of cold vegetable for. on 4/3/12 at 5:35 p.m., ited dietary staff did not have beef stroganoff or tossed. Dietary Staff H located a seed salad. On 4/4/12 at 8:12 presented a pureed recipe or sundated "dysphagia puree serole" instructed staff to "and add "1 tablespoon of "s undated recipe for "pureed ds" and "tossed salad" st serving as 5 servings. For ite indicated to use 1 1/4 quart finch as "tossed or garden", 2 and 1/2 cup of Italian dressing on 4/4/12 at 4:20 p.m. Dietary staff failed to follow the approved recipe for beef	F	363			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E071	B. WIN	3		04/1	1/2012
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	cu	·	50	EET ADDRESS, CITY, STATE, ZIP CODE 6 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 363	o failure to use Italian vegetable juice in the During an interview or Consultant Staff J confollow the beef strogated salad recipes as approdiction. The facility failed to expureed diet received needs of the resident recommended dietary failed to follow the recommended result one non-sampled result 483.35(i) FOOD PROSTORE/PREPARE/STOR	d to the tossed lettuce salad in dressing or milk instead of tossed lettuce salad. In 4/5/12 at 1:50 p.m. MST, infirmed the facility failed to anoff and tossed lettuce roved by the registered Insure one resident on a foods that met the nutritional in accordance with the y allowances. The facility cipes for pureed foods for ident. INCURE, INERVE - SANITARY In sources approved or my by Federal, State or local estribute and serve food		3371			
	by: The facility reported with one kitchen and	-					
	Based on observation review, the facility fail	n, interview, and record led to store, prepare,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		17E071	B. WIN	IG_		04/1	1/2012
	OVIDER OR SUPPLIER	си		5	REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 FRIBUNE, KS 67879		··· -
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 371	resident #6. Findings included: - Observations on 4/2 and 11:31 a.m. MST revealed Dietary Staff residents' clothing, wh tops, and backs of restouched the eating sucake with the thumbor glove that he/she service dead Dietary Staff counter, each resident his/her shirt. Dietary resident's foiled bake potato with his/her coplaced a slice of breawith his/her contamination. Observations on 4/2/12:21 p.m. MST revealed Dietary Staff counter, each resident with his/her contamination. Observations on 4/2/12:21 p.m. MST revealed bis/her nose for and failed to clean his resident #6 with the lucture. Observations on 4/3/12 revealed Dietary Staff service counter, a car	cred all residents including 2/12 between 11:25 a.m. (Mountain Standard Time) F touched multiple neelchair handles, table sidents' chairs while he/she rface of plates of strawberry of his/her contaminated ved to each resident. 12 at 11:53 p.m. MST F V touched the steam table it's laminated food card, and Staff V opened each d potato, removed the ntaminated glove, and d on each resident's place ated gloved hand. 12 between 12:18 p.m. and aled Direct Care Staff G ur times on his/her pants is/her hands prior to assisting unch meal. 12 at 5:12 p.m. MST F T touched the kitchen t handle, and his/her shirt	F	371			
	potato with his/her co placed a slice of brea with his/her contaminated with his/her contaminated by the place of the plac	ntaminated glove, and d on each resident's place ated gloved hand. I2 between 12:18 p.m. and aled Direct Care Staff G ur times on his/her pants s/her hands prior to assisting unch meal. I2 at 5:12 p.m. MST					
	Observations on 4/3/	12 at 5:41 p.m. MST					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SUF COMPLETI	
		17E071	B. WIN	G		04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	CU	•	506	ET ADDRESS, CITY, STATE, ZIP CODE 6 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 371	counter, his/her shift, steamed food, the rescards, then placed sliresident's plate with house of the country staff his/her shirt, and servesident's plates with Dietary Staff T touched bowl with the thumbour of gloved hand and place pudding in each resident of the country staff H confirms food to residents in a remove soiled gloves new gloves before confood. During an interview of Administrative Nursing failed to serve food to manner by failing to confood to the country of the country of the facility's 3/22/12 of the country of the country of the facility of the country of the facility failed to disanitary manner by failed to disanitary manne	I U touched the steam table lid handles over the sidents' laminated food ced bread on to each is/her contaminated gloves. I 2 at 5:42 p.m. MST I Touched a cart handle, ed potato chips on to each the contaminated gloves. In the contaminated gloves at the eating surface of each of his/her contaminated ed a scoop of yellow ent's bowl. In 4/4/12 at 4:20 p.m. MST, and staff failed to serve sanitary manner by failing to clean hands, and place intact with the residents' In 4/5/12 at 12:50 p.m. MST, and Staff A confirmed staff residents in a sanitary lean their hands when a gresidents to eat. I Food Safety and Sanitation" to wash their hands when nands in an unsanitary way leandling residents. The ons in relation to use of	F	371			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		17E071	B. WIN	G		04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	cu		50	REET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 371	(Mountain Standard T gallon container of va (ounces) container of opened and undated Further observations container of cottage of container of whipped bag with approximate cheese that lacked a activity area refrigeral Observations on 4/2/r revealed an opened a rye bread in the kitched During an interview of Dietary Staff H confirmedate on items opened refrigerator and the kitched The facility's 3/22/12 instructed staff to place "to indicate that date or ready-to-eat, potential be consumed, sold, of all high risk food." The facility failed to stamp opened cottage chees the activity area refrigand strawberry ice created and undated the activity area refrigand strawberry ice created the activity area refrigand strawberry ice created to stamp opened cottage chees the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigand strawberry ice created to stamp opened cottage cheese the activity area refrigance cheese the activ	ing resident #6. 2/12 at 10:35 a.m. MST Time) revealed a 1/8 full, 1 nilla ice and 1/2 full, 56 oz strawberry ice cream in the activity area freezer. revealed a 1/8 full, 24 oz cheese, a 1/2 full, 6 oz cream, and small ziplock ly 20 cubes of yellow date when opened in the for. 12 at 10:40 a.m. MST and undated bag of sliced en's walk-in freezer. 14/3/12 at 5:30 p.m. MST, med staff failed to place a 1 in the activity room tchen's walk in freezer. 15 rood Storage" policy the a date on opened items for day by which a lly hazardous food should ar discarded will be visible on 16 rore food in a sanitary for and whipped cream in for and whipped cream in for and had been on opened vanilla for and the activity area for and bag of rye bread in the	F	371			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ULTIPLE LDING	CONSTRUCTION	(X3) DATE SUP COMPLET	
		17E071	B. WIN	IG		04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си	,	506	T ADDRESS, CITY, STATE, ZIP CODE THIRD PO BOX 338 BUNE, KS 67879	, , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 371	5:30 p.m. MST reveal failed to monitor the to beef stroganoff or tos. Observations on 4/4/revealed a salad bary cheese available for adjacent to the dining. Review of the facility's "Food Temperature Lemonitor pureed or coleach meal. The facility's undated diet for casserole" received to serving temperature degrees Fahrenheit. The facility's undated salads (tossed salad) cover and refrigerate Fahrenheit. During an interview of Dietary Staff H confirmed the pureed beef strogand cold items such a serving to the resident The facility failed to posanitary conditions by temperatures of purees serving.	3/12 between 5:04 p.m. and led Dietary Staff T and U emperature of the pureed sed salad prior to service. 12 at 11:41 a.m. MST which included cottage residents in the hallway area. 3 March 2012 and April 2012 ogs" revealed staff failed to d items prior to service at "Dysphagia puree (level 1) sipe instructed staff to heat e of a minimum of 140 "Pureed vegetables and "recipe instructed staff to below 38 degrees 1 4/4/12 at 4:20 p.m. MST, med staff failed to monitor anoff, pureed tossed salad, as cottage cheese prior to tts.	F	371			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLET	
		17E071	B. WING	<u> </u>	04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		STREET ADDRESS, CITY, STATE, ZIP C 506 THIRD PO BOX 338 TRIBUNE, KS 67879	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 371	During an interview of Dietary Staff X reports solution prior to the estaff X reported staff x reported staff x reported staff sanitation solution to parts-per-million (ppm Upon request on 4/3/Dietary Staff X obtain facility's kitchen and pasanitation solution. Otest strip failed to chathe manufacturer's instest strip container. Observations on 4/3/revealed Dietary Staff X and placed a test strip container to the facility MST, Dietary Staff X and placed a test strip container solution. Otest strip changed from indicated 200 ppm on instructions. Observations of the sanitation dining an interview of Dietary Staff H confirm ppm of the sanitation dining area tables. Review of an undated.	dining area tables with a ragion solution. In 4/3/12 at 9:15 a.m. MST, ed staff filled the sanitation and of each meal. Dietary did not usually monitor the contain 200 to 400 a) prior to use. In 2 at 9:17 a.m. MST, ed test strips from the blaced the test strip in the blaced the test strip in the blaced the indicated by structions as "0" ppm on the structions as "0" ppm on the structions as "0" ppm on the polytopic polytopic ppm on the structions as "0" ppm on the structions as "0" ppm on the polytopic ppm on the polytopic ppm on the structions as "0" ppm on the pp	F3	571		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SUI COMPLET	
		17E071	B. WIN	G		04/1	1/2012
	COUNTY HOSPITAL LT	си	•	506	T ADDRESS, CITY, STATE, ZIP CODE THIRD PO BOX 338 BUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	solution prior to each surfaces. The facility failed to so conditions by failing to	anitation container with use on dining and kitchen erve food under sanitary o sanitize the dining areas	F	371			
F 372 SS=C	PROPERLY	als. E GARBAGE & REFUSE ose of garbage and refuse	F	372			
	by:	is not met as evidenced a census of 25 residents					
	review, the facility fail and refuse properly (n, interview, and record ed to dispose of garbage close the lids to the south ays which overflowed with s).					
		2/12 at 10:40 a.m. MST Fime) revealed one of the					
	·	the south side of the facility					
	revealed one of the tw south side of the facili	vo dumpster lids on the ity in the opened position.					
	Observations on 4/4/r revealed refuse in a la	12 at 1:15 p.m. MST arge, black bag overflowed					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING		(X3) DATE SUF	
		17E071	B. WIN	IG		04/1	1/2012
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	си	_	5	REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 TRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 372	from the upper portion dumpster and 4 large approximately 10 feet the base of the facility. Housekeeping/Mainte walked from a parked bags of refuse and pla dumpster but failed to overflowing. During an interview of Housekeeping/Mainter reported the kitchen standard the facility but all other the south side of the fack of awareness of remained overflowing the city usually picked. During an interview of Housekeeping/Mainter reported a lack of awareness of remained overflowing the city usually picked. During an interview of Housekeeping/Mainter reported a lack of awareness of the city usually picked. Observed with refusilities remained opened Housekeeping/Mainter confirmed the facility and refuse properly. Observations on 4/5/2 revealed the south duroverflowing with refusifialled to close secure.	n of the opened south, black refuse bags placed away from the dumpster at a bricked stairs. In ance/Laundry Staff W vehicle to the 4 large, black aced each bag in the keep the refuse from In 4/4/12 at 1:19 p.m., enance/Laundry Staff W regularly used other another parking lot north of a staff used the dumpster on facility. Staff W reported a why the south dumpster with refuse and reported dup trash on a timely basis. In 4/4/12 at 1:54 p.m. MST, enance/Laundry Staff S areness until a few hours that the south dumpster e and at least one of the two between 4/2/12 to 4/4/12. Enance/Laundry Staff S failed to dispose of garbage 12 at 6:30 a.m. MST impster remained are and two of the two lids by.	F	372			
		olicy regarding the proper ated to the dumpsters.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E071	B. WIN	G		04/1	1/2012
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	cu		50	REET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 372	refuse properly by fai south dumpster 4 out with refuse 2 of the 4 483.60(c) DRUG REG	ispose of garbage and ling to close the lids to the of 4 days which overflowed days. GIMEN REVIEW, REPORT		372 428			
SS=E	The drug regimen of	each resident must be e a month by a licensed					
	the attending physicia	report any irregularities to an, and the director of ports must be acted upon.					
	by: The facility reported with 10 residents sam medication review. Based on observation review, the facility fail consultant reported in and the director of nu Warnings for 10 of the	is not met as evidenced a census of 25 residents appled for unnecessary n, interview, and record led to ensure the pharmacist regularities to the physician arsing regarding Black Box e 10 reviewed residents 16, 26, 18, 2, and 17).					
	included diagnoses o hypokalemia, hypoma	· · · · ·					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E071	B. WIN	G		04/1	1/2012
	COUNTY HOSPITAL LT	cu		50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	peripheral vascular di stenosis, hypertensio arthritis. The 2/29/12 an order for Seroquel medication) 25 mg (mevening for agitation. Resident #15's 1/22/12 Data Set) Assessmer impaired cognition, mantipsychotic and ant Resident #15's 9/28/12 mention the resident Seroquel's Black Box Resident #15's monthreviews between Sep 2012 lacked document to mention Seroquel's resident's care plan. According to blackbox (Quetiapine) increase patients with demention than placebo. Observations on 4/3/Standard Time) reveau bedroom recliner with covered by a blanket, elevated on the reclin During an interview or Consultant Staff E requeed to alert staff of the	type 2 diabetes mellitus, sease, lumbar spinal n, and degenerative knee physician's orders included (an antipsychotic nilligrams) by mouth every 12 Quarterly MDS (Minimum nt reported moderately ild depression, and received idepressant medications. 1 care plan failed to received Seroquel or Warning. 1 ly medication regime tember 2011 and March ntation that the facility failed is black box warning in the serx.com, Seroquel and mortality in elderly a related psychosis greater 12 1:14 p.m. MST (Mountain alled the resident sat in a a call light within reach, and his/her legs remained	F	428			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		17E071	B. WIN	G	·····	04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		5	REET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 TRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	warnings in the resided. The facility failed to electronsultant reported in and the director of nur Black Box Warning for a Resident #27's 3/9/included diagnoses of atrial fibrillation, hypothypercholesterolemia without behavioral disdisorder, glaucoma, harteriosclerosis, osteoregion, and a pacema orders renewed order medication) 200 mg (mand Acetaminophen (medication) 500 mg b 650 mg by mouth ever pain. Resident #27's 3/23/1 Data Set) Assessment cognition and the resist special category of medication and the resist speci	ents' care plans. Insure the pharmacist regularities to the physician raing related to Seroquel's resident #15. 12 physician's orders for congestive heart failure, thyroidism, hypopotassemia, dementia turbances, depressive ypertension, coronary parthrosis of pelvic and thigh laker. The 3/9/12 physician's sof for Amiodorone (a heart milligrams) by mouth daily a pain and fever by mouth at breakfast and ary four hours as needed for 2 Annual MDS I(Minimum at reported severely impaired dent did not receive a edications. I lacked mention of black bodorone or Acetaminophen. Illy medication regime tember 2011 and March patation that the facility failed warnings for Amiodorone or a residents care plan.	F	428			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	DING	<u></u>	(X3) DATE SUR COMPLETE	
		17E071	B. WIN	G		04/1	1/2012
	COUNTY HOSPITAL LT	си		5	REET ADDRESS, CITY, STATE, ZIP CODE 106 THIRD PO BOX 338 TRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 428	effort should be made first and liver injury is but is usually mild and abnormal liver enzymoccur, however, and I cases." According to blackbookeld the "potential for warning highlighting threactions (e.g., swelling throat, difficulty breath being added to the lall products that contain Cobservations on 4/4/2 (Mountain Standard Tambulated independent steady gait. During an interview of Consultant Staff E represed to alert staff of beconfirmed the facility warnings in the resident The facility failed to econsultant reported in and the director of nu warnings for Amiodor resident #27. Resident #10's physfollowing diagnoses of hypertension, depressions	e life-threatening in a sudden death, so that every to utilize alternative agents common with Cordarone, devidenced only by less. Overt liver disease can has been fatal in a few arx.com, Acetaminophen severe liver injury and a he potential for allergicing of the face, mouth, and hing, itching, or rash) [were] loel of all prescription drug acetaminophen." 12 11:05 a.m. MST lime) revealed resident #27 antly in his/her room with a lack box warnings and failed to mention black box ents' care plans.	F	428			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E071	B. WIN	G		04/1	1/2012
	COUNTY HOSPITAL LT	cu	I	50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	hypothyroidism and order sheet also inclupatch 50 mcg (microg 72 hours for pain. Resident #10's 2/4/12 Assessment indicated moderately impaired received an antidepreassessment period. Resident #10's 2/2/12 any monitoring for sideractions from the usblack box warnings. According to blackbomedication contained Fentanyl: "This productoncentration of a poagonist, fentanyl. Schave the highest poteassociated risk of fatarespiratory depression. Review of resident #7 Regimen Review for of information related. On 4/4/12 at 6:35 a.n. time, direct care staff #10 with morning carsigns of depression of during cares. An interview with lice 8:30 a.m. MST confired.	constipation. The physician ided an order for Fentanyl grams) to be changed every 2 Quarterly MDS d the resident had a cognitive status and essant medication during the 2 Care Plan failed to mention de effects or adverse e of medications which had 2 xxx.com, the following black box warnings: ict contains a high tent Schedule 2 opioid substances ential for abuse and all overdose due to	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	JLTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
		17E071	B. WINC	<u> </u>	-	/11/2012
	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP (506 THIRD PO BOX 338 TRIBUNE, KS 67879	•	711/2012
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F 428	During an interview consultant E report the need for black He/she reported the record currently ide BBWs, but had not into the nursing ca. The facility failed to pharmacist reported attending physicial related to resident had a black box was a Besident #20's 2 listed diagnoses of mental disorder, Phypertension, hypocoronary atherosol and osteoarthrosis also had an order at hour of sleep. Resident #20's 12/Data Set) assessmintact cognition, no received antidepred the resident's 12/2 information related depression, however information related seroquel which has a According to black.	or e residents nursing care plans. If you also on 4/5/12 at 10:55 a.m. MST, ted recently becoming aware of box warnings on care plans. If you also on the medication administration entified medications with a incorporated the information re plans. If you also on the consultant and any irregularities to the analytic and the director of nursing as #10's use of Fentanyl, which	FZ	128		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	_DING		(X3) DATE SUR COMPLETE	
		17E071	B. WIN	G		04/1 ⁻	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		5	REET ADDRESS, CITY, STATE, ZIP CODE 106 THIRD PO BOX 338 TRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 428	psychosis treated with drugs are at an increate to placebo" and "close thinking or unusual characteristics. During an observation MST (Mountain Standat the dining room tab resident had no inappet the meal. An interview on 4/4/12 licensed staff C reveal care plan did not inclumedications that had. During an interview of consultant E reported the need for black bothe/she reported the record currently identified by the she reported the nursing care. The facility failed to expharmacist reported attending physician at related to resident #20 had a BBW. Resident #12's physical following diagnoses of degeneration, hyperteristics.	an atypical antipsychotic ased risk of death compared to observation for suicidal anges in behavior." In on 4/4/12 at 11:30 a.m. that Time), resident #20 sat ole after eating a meal. The propriate behaviors during It at 2:34pm MST with alled resident #20's nursing and information related to BBWs. In 4/5/12 at 10:55 a.m. MST, recently becoming aware of a warnings on care plans. In a warnings on care plans and instration administration and infeed medications with corporated the information olans. Insure the consultant any irregularities to the and the director of nursing as 0's use of Seroquel which are sicians order sheet listed the financial hypopotaassemia, n's disease, macular ension, coronary epsia, vertigo, chronic	F	428			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		17E071	B. WIN	G		04/1	1/2012
	COUNTY HOSPITAL LT	CU	,	50	EET ADDRESS, CITY, STATE, ZIP CODE 16 THIRD PO BOX 338 RIBUNE, KS 67879	, , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 428	Continued From page	e 64	F	428			
	Data Set) Assessmer Quarterly MDS indica cognition. Resident #12's Care monitoring for side ef	11 Annual MDS (Minimum nt and the 10/20/11 ted severely impaired Plan failed to mention any fects or adverse reactions eations which had black box					
	warnings.						
	withdrawn abruptly (p coronary artery disea	a black box warning: therapy should not be articularly in patients with se) but gradually tapered avoid acute tachycardia,					
	Regimen Review for	2's monthly Medication the past year revealed a lack to black box warnings.					
	On 4/4/12 at 8:15 a.m ambulated with stead assisted by direct car	y gait to the bathroom while					
	8:30 a.m. MST confirmedications with blace	nsed staff C on 4/4/12 at med that monitoring for k box warnings had not residents' nursing care					
	consultant E reported the need for black bo	n 4/5/12 at 10:55 a.m. MST recently becoming aware of x warnings on care plans. nedication administration ified medications with					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		17E071	B. WIN	IG_		04/1	1/2012
	COUNTY HOSPITAL LT	си	'	ŧ	REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 TRIBUNE, KS 67879	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	BBWs, but had not incinto the nursing care into the nursing attending physician at related to resident #15 a black box warning. Resident #16's 3/8/included diagnoses or hypothyroidism, hypothyroidism, hypothyroidism, congest cerebral atherosclerosinsomnia. The physicion order for Seroquel 25 sleep. Resident #16's 1/29/1 data set) assessment intact cognition and reantidepressant medicion. Resident #16's currer information related to however, lacked any potential side effects related to the use of State (Black Box Warning). According to blackbox this BBW, "Elderly papsychosis treated with drugs are at an increasion."	corporated the information plans. Insure the consultant any irregularities to the and the director of nursing as 2's use of Toprol which had 12 physician order sheet anxiety state, potassemia, dementia, macular degeneration, tive heart failure, dyspepsia, sis, osteoarthosis, and cian order sheet included an any (milligrams) at hour of 2 quarterly MDS (minimum revealed the resident had acceived antipsychotic and ations. In the nursing care plan included anxiety and depression, information regarding and adverse reactions beroquel which had a BBW Arx.com, Seroquel contained tients with dementia related in atypical antipsychotic ased risk of death compared to observation for suicidal	F	428			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E071	B. WIN	G		04/1	1/2012
	COUNTY HOSPITAL LT	си		50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	MST (Mountain Standambulated independent steady gait and did not depression or inapproach an interview on 4/4/12 licensed staff C reveau care plan did not inclumedications that had During an interview of administrative nurse of administrative nurse of currently did not inclumedications that had During an interview of administrative nurse of currently did not inclumed the need for black bothe/she reported the need for black bothe/she reported the need for black bothe/she reported the nursing care plant and the nursing care plant facility failed to expharmacist reported attending physician and related to resident #10 had a BBW. The signed Physician and a BBW. The signed Physician and the subendocardial infarct failure, anemia, sleep depressive disorder, of diseases and abnorm other specified hemip affecting unspecified signed and the standard signed and the standard signed signed and the standard signed si	an on 4/3/12 at 3:00 p.m. dard Time), resident #16 ently in the hallway with a of exhibit any signs of opriate behaviors. 2 at 2:34 p.m. MST with alled resident #16's nursing ude information related to BBWs. 3 at 4/4/12 at 3:30 p.m. MST, a confirmed the facility de information regarding is nursing care plans. 3 at 4/5/12 at 10:55 a.m. MST, a confirmed the facility de information regarding is nursing care plans. 3 at 4/5/12 at 10:55 a.m. MST, a confirmed the facility de information regarding is nursing care plans. 4/5/12 at 10:55 a.m. MST, a recently becoming aware of a warnings on care plans. In a confident medication administration in the direction administration in the corporated the information plans. 4 an order dated 2/1/2012 and diagnoses of tion, congestive heart arousal disorder,	F	428			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		17E071	B. WIN	G		04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си	•	506	EET ADDRESS, CITY, STATE, ZIP CODE 6 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 428	of unspecified type of ischemia, late effects constipation, hemorrh pain in joint involving muscle weakness, os giddiness, insomnia, incontinence, history system not elsewhere Resident #2's signed 2/1/2012 included an milligrams. The 2/24/2012 Quarte set) assessment for rewith severely impaire behaviors, no reporte pain received pain me Resident #2's 4/3/201 direction to staff relatively high and the potential process of the process of	ressel, transient cerebral of cerebrovascular disease, lage of gastrointestinal tract, multiple sites, general teoporosis, dizziness and weight loss, diarrhea, urinary of diseases of circulatory e classified. Physician Orders dated order for Tylenol 500 Physician Orders dated order for Tylenol 5	F	428			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	CTION (X3) DATE SURVE COMPLETED	
		17E071	B. WIN	G		04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си	•	50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	(Mountain Standard T staff A verified that re information related to Tylenol. During an interview o MST, consultant staff a medication that con and staff needed to k related to resident #2 The facility failed to e receive unnecessary adequate monitoring) monitor for potential s reactions as related to - The signed Physicia for resident #17 include failure to thrive, dehyo vitamin B deficiency, hypopotassemia, atyp tobacco use disorder, Parkinson's disease, cerebral aneurysm no obstruction, dyspepsi bladder, osteoarthros of venous thrombosis use of anticoagulants Resident #2's signed 2/1/2012 included ord milligrams, Tylenol 50, 15milligrams, and Co	in 4/4/2012 at 5:15 p.m. MST Time), administrative nursing sident #2's care plan lacked the Black Box Warning for in 4/5/2012 at 10:52 a.m. E verified resident #2 took tained a Black Box Warning now that information as it 's Tylenol. Insure resident #2 did not drugs (drugs used without when the facility failed to side effects and adverse b BBWs for Tylenol. In Orders dated 3/1/2012 ded diagnoses of adult dration, hypothyroidism, vitamin D deficiency, pical depressive disorder, Alzheimer's disease, essential hypertension, onruptured, chronic airway a, constipation, neurogenic is, insomnia, edema, history and embolism, long term Physician Orders dated ders for Fluoxetine 20 on milligrams, Remeron	F	428			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		17E071	B. WIN	IG		04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		5	REET ADDRESS, CITY, STATE, ZIP CODE 106 THIRD PO BOX 338 TRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	resident as cognitively noted, urine incontine received pain medica. Resident #17's 4/3/20 direction to staff relate Tylenol, Remeron, an BBWs (Black Box Wath According to blackbox medications contained of Fluoxetine: patients the potential for clinic unusual changes in botylenol: Acetamino potential for causing sthe potential for causing streaming, suicidality behavior. O Coumadin: Coumac potential to cause mateginning of therapy stresulting in a higher II Normalized Ratio). Record review of pharevealed resident #17 or irregularities for Fe December, or Septem had a risk/benefit stat support the continued.	y intact with no behaviors nce, occasional pain and tion and an antidepressant. 112 nursing care plan lacked ed to the use of Fluoxetine, d Coumadin which all had rnings). 12 nursing care plan lacked ed to the use of Fluoxetine, d Coumadin which all had rnings). 13 nursing care plan lacked ed to the use of Fluoxetine, d Coumadin which all had rnings). 14 nursing care plan lacked ed to the use of Fluoxetine, depth and land and land land land land land l	F	428			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		17E071	B. WIN	IG_		04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си	.	5	REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 FRIBUNE, KS 67879	, , , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	K and L assisted residence the bathroom. Residence symptoms of pain or of transfer and ambulating and cooperative with. During an interview of (Mountain Standard Itstaff A verified that relacked information relacked information relacked information (Warfather Elacked Itstaff Information (Warfather Elacked Information (Warfathe	dent #17 out of bed and to ant #17 had no signs or distress noted during on. Resident remained calm staff members. In 4/4/2012 at 5:15 p.m. MST Time), administrative nursing sident #17's care plan ated to Black Box Warning oil, Remeron (Mirtazapine), arin). In 4/5/2012 at 10:52 a.m. E verified resident #17 took ained a Black Box Warning now that information as it 7's Fluoxetine, Tylenol, adin. In sure resident #17 did not drugs (drugs used without when the pharmacist failed edication or medication nificant potential for adverse dication interactions related ne, Tylenol, Remeron, and	F	428			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	_DING		(X3) DATE SUR COMPLETE	
		17E071	B. WIN	G		04/1	1/2012
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		5	REET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 428	Continued From page The Quarterly (MDS) 2/21/12 indicated resi impaired cognitive cognitive cognitive resident #2 care plan lacked direct potential side effects amedication with BBW Review of resident #2 Regimen review reverselated to black box was according to www.blamedication contained Acetaminophen: "In a highlighting the potential and a Warning highlighting allergic reactions (e.g. mouth, and throat, differash) are being added prescription drug product acceptation of the product of the produ	Minimal Data Set on dent #26 had severely gnition and received by. 6's care plan revealed the etion to staff regarding and adverse reaction of (black box warning). 6's monthly Medication aled lack of information rarnings for the past year. ckboxrx.com the following black box warnings: addition, a Boxed Warning tial for severe liver injury thing the potential for swelling of the face, ficulty breathing, itching, or it to the label of all lucts that contain a potent diuretic which, if nounts, may lead to a water and electrolyte careful medical supervision and dose schedule must be lual patients needs (see		428		PRIATE	DATE
	withdrawn abruptly bu acute tachycardia, hy ischemia". Coumadin: " May cau	er therapy should not be It gradually tapered to avoid pertension, and/or se major or fatal bleeding." I. MST (mountain standard					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		17E071	B. WIN	G		04/1	1/2012
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си	•	50	REET ADDRESS, CITY, STATE, ZIP CODE 106 THIRD PO BOX 338 TRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	26 with activities of daremained calm and command calm and calm	K and M assisted resident # aily living. The resident properative with cares. In 4/4/12 at 12:30 p.m. MST a confirmed resident # 26's ked information regarding and adverse reactions of s. In 4/5/12 at 10:55 a.m. MST, recently becoming aware of ke warnings on care plans, redication administration administration and infed medications with corporated the information plans. Insure the consultant any irregularities to the and the director of nursing as 6's use of Acetaminaphen, coumadin which had black In 2 physicians order sheet ronic ischemic heart and the director of nursing as 6's use of Acetaminaphen, coumadin which had black In 2 physicians order sheet ronic ischemic heart disease, sm, vitamin D deficiency as, dysthymic disorder, diseases and abnormal congestive heart failure, requency, long-term use of ania, calculus of kidney, and	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		17E071	B. WING	i	- 04/·	11/2012	
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		STREET ADDRESS, CITY, STATE, 2 506 THIRD PO BOX 338 TRIBUNE, KS 67879	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 428	assessments for resident had moderate behaviors and received. Residents #18's care direction to staff regal and adverse reaction. Lasix, Cuprimine, Ate had BBWs (Black Box). According to www.blamedication contained. Acetaminophen: "In a highlighting the poten and a Warning highlighting allergic reactions (e.g., mouth, and throat, differash) are being added prescription drug produce taminophen." Lasix: "This agent is a given in excessive amprofound diuresis with depletion. Therefore, is required, and dose adjusted to the individence of the product of the moderations, and the penicillamine should in the penicillamine should in Each patient should in Each patient should in the service of the should in the service of	din. (Minimal Data Set) on Interly MDS on 1/3/12 Ilent #18 indicated the ely impaired cognition, no ed antidepressants. plan on 4/3/12 lacked rding potential side effects related to Acetaminophen, molol and Coumadin, which warning). ckboxrx.com the following black box warnings: ddition, a Boxed Warning tial for severe liver injury thing the potential for, swelling of the face, ficulty breathing, itching, or it to the label of all lucts that contain a potent diuretic which, if injurity, may lead to a water and electrolyte careful medical supervision and dose schedule must be lual patients needs (see NISTRATION)." Ins planning to use horoughly familiarize xicity, special dosage	F 4	28			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X5) A. BUILDING		(X3) DATE SURVEY COMPLETED				
		17E071	B. WIN	G_		04/1	1/2012
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		5	REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 FRIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 428	withdrawn abruptly bu acute tachycardia, hy ischemia." Coumadin: "May cau Review of resident #1 Regimen Review reverelated to black box w 2011 through March 2 Observations of resid p.m. MST (mountain alert, cooperative, cal During an interview o licensed staff B confir care plan lacked inforside effects and advewith BBWs. During an interview o consultant E reported the need for black bothe/she reported the need for black bothe/she reported the nursing care in the facility failed to e pharmacist reported attending physician a related to resident #1 Lasix, Cuprimine, Ate	report promptly any toxicity ". er therapy should not be at gradually tapered to avoid pertension, and/or se major or fatal bleeding." 8's monthly Medication ealed a lack of information varnings from November 2012. ent #18 on 4/3/12 at 4:15 standard time) revealed an m, and oriented resident. 10 4/4/12 at 12:30 p.m. MST, med that resident # 18's mation related to potential rise reactions to medications 11 4/5/12 at 10:55 a.m. MST, recently becoming aware of a warnings on care plans. The redication administration iffied medications with corporated the information plans. 11 any irregularities to the modified to defect of nursing as 8's use of Acetaminaphen, molol, and Coumadin which	F	428			
F 431	had black box warnin 483.60(b), (d), (e) DR	•	F	431			

	OF DEFICIENCIES CORRECTION	RECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E071	B. WING	3		4/11/2012
	COUNTY HOSPITAL L	тси		STREET ADDRESS, CITY, S' 506 THIRD PO BOX 338 TRIBUNE, KS 67879	TATE, ZIP CODE	711/2012
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431 SS=E	The facility must em a licensed pharmaci of records of receipt controlled drugs in s accurate reconciliati records are in order controlled drugs is mareconciled. Drugs and biological labeled in accordance professional principle appropriate accessor instructions, and the applicable. In accordance with stacility must store all locked compartment controls, and permit have access to the key to the facility must propermanently affixed controlled drugs listed Comprehensive Dru Control Act of 1976 abuse, except when package drug distributed.	ploy or obtain the services of st who establishes a system and disposition of all ufficient detail to enable an on; and determines that drug and that an account of all naintained and periodically sused in the facility must be be with currently accepted es, and include the ary and cautionary expiration date when state and Federal laws, the drugs and biologicals in sunder proper temperature only authorized personnel to	F 4	31		
	This REQUIREMEN by:	T is not met as evidenced				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E071	B. WIN	B. WING		04/11/2012	
	ROVIDER OR SUPPLIER	cu	·	50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 431	stored injectable med located in the East har rooms. Based on observation review the facility faile biologicals used in the currently accepted pre (Multi-dose vial of infl multi-dose vials of vitinsulin for resident #3 resident #15) Findings included: - An observation on a (Mountain Standard 1) staff charting room more of the company of the compa	nsus of 25 residents and lications in refrigerators all and South hall charting and, interview, and record ed to label drugs and e facility in accordance with ofessional principles. uenza vaccine for stock use, amin B12 and Humalog et, and Novolog insulin for all of influenza vaccine with edication refrigerator had an eal of influenza vaccine with edication refrigerator had an eal of influenza vaccine with edication refrigerator had an eal of influenza vaccine with edication services and pened multi-dose divial of Humalog insulin pened. Both medications #3. The south hall or also had an opened vial of no date when opened for a 4/3/2012 at 3:50 p.m. nursing staff A verified staff edivials of medication and	F	431			

Facility ID: H036101

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E071	B. WING			04/11/2012	
	VIDER OR SUPPLIER	cu		50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441 2 SS=E S t t c c c c c c c c c c c c c c c c c	have a date. The policinformation for when the information for when the medications. According to www.humalog. Insulin site, once operater 28 days. According to www.noventtp://www.novolog.cinsulin site, once operater 28 days. The facility failed to law used in the facility in a facepted professional of influenza vaccine for vials of vitamin B12 and resident #3, and Novolassional for the facility must establinfection Control Prografe, sanitary and control prografe, sanitary and control prografe, sanitary and control prografe. (a) Infection Control Formation in the facility must establing program under which (1) Investigates, control the facility; (2) Decides what program under which capplied to a should be applied to a sh	ons, once opened, should cy lacked specific to discard opened injectable malog.com .com>, the official Humalog ned, discard Humalog vials volog.com .com>, the official Novolog ned, discard Novolog vials abel drugs and biologicals accordance with currently of principles. (Multi-dose vial or stock use, multi-dose and Humalog insulin for colog insulin for resident #15) CONTROL, PREVENT blish and maintain an gram designed to provide a maintain and evelopment and transmission on. Program blish an Infection Control		441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	17E071 B. WING			04/1	1/2012		
	COUNTY HOSPITAL LT	си	1	506	ET ADDRESS, CITY, STATE, ZIP CODE 5 THIRD PO BOX 338 LIBUNE, KS 67879	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		I	ID PROVIDER'S PLAN O PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO DEFICIEN		LD BE	(X5) COMPLETION DATE
F 441	prevent the spread of isolate the resident. (2) The facility must promunicable disease from direct contact will transport (3) The facility must rehands after each direct hand washing is indicented professional practice. (c) Linens Personnel must hand	d of Infection n Control Program ident needs isolation to infection, the facility must prohibit employees with a see or infected skin lesions th residents or their food, if asmit the disease. equire staff to wash their ct resident contact for which	F	441			
	by: The facility reported and the sample contains and the sample contains and the sample contains and the facility faile environment and previous transmission of diseast aff failed to wash the resident contact and the hygiene with use of gaccepted professional failed to clean and distance a	n, interview, and record ed to provide a sanitary vent the development and se and infection. The facility eir hands after each direct demonstrate proper hand					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BU			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		17E071	B. WIN	IG_		04/11/2012		
	COUNTY HOSPITAL LT	си	'	5	REET ADDRESS, CITY, STATE, ZIP CODE 506 THIRD PO BOX 338 TRIBUNE, KS 67879	, , , , , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 441	Continued From page	÷ 79	F	441				
	Findings included:							
	MST (Mountain Stand	on on 4/4/2012 at 9:40 a.m. dard Time), licensed nursing ze the glucometer after od sugar checks.						
	MST, licensed nursing failed to sanitize the continuous licensed nursing staff.	n 4/4/2012 at 9:45 a.m. g staff B verified he/she glucometer after use. f B verified the facility had 2 od sugar checks 4 times						
		he facility lacked a policy nitizing the glucometer						
	MST, direct care staff	n on 4/4/2012 at 8:45 a.m. L failed to wash or sanitize emoving gloves after he/she n a resident.						
	MST, direct care staff	n on 4/4/2012 at 8:50 a.m. K failed to wear gloves to the dirty utility room.						
	MST, direct care staff	n 4/4/2012 at 9:05 a.m. L verified he/she failed to ze his/her hands after es.						
	MST, direct care staff	n on 4/4/2012 at 9:15 a.m. N failed to wash or sanitize emoving gloves after he/she n a resident.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E071	B. WING			04/11/2012	
	OVIDER OR SUPPLIER COUNTY HOSPITAL LT	си		50	EET ADDRESS, CITY, STATE, ZIP CODE 6 THIRD PO BOX 338 RIBUNE, KS 67879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 456 SS=F	MST, direct care staff his/her hands upon re handled soiled linens wear gloves to transp soiled linen to the dirt. During an interview of MST, direct care staff wash or sanitize his/resident care tasks. During an interview of MST, direct care staff wear gloves to transproom. During an interview of MST, administrative restaff received hand word 2012. Administrative restaff received hand word 2012. Administrative that staff should wash gloves and staff should handling trash or soiled. The facility failed to penvironment and prevent ransmission of diseas staff failed to wash the resident contact and the hygiene with use of gaccepted professional failed to clean and dismultiple residents. (2 483.70(c)(2) ESSENTOPERATING CONDITION.	in on 4/4/2012 at 9:15 a.m. If P failed to wash or sanitize emoving gloves after he/she in Direct care staff P failed to port the sacks of trash and by utility room. In 4/4/2012 at 9:30 a.m. If N verified he/she failed to per hands between different in 4/4/2012 at 9:30 a.m. If P verified he/she failed to per hands between different in 4/4/2012 at 5:15 p.m. In a further to the dirty utility in 4/4/2012 at 5:15 p.m. In a further to the dirty utility in a further to a furth		441			
55 = ⊦	The facility must main						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIP _DING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E071	B. WIN	B. WING		04/11/2012	
	COUNTY HOSPITAL LT	си	,	5	REET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 TRIBUNE, KS 67879	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 456	mechanical, electrical equipment in safe operations. This REQUIREMENT by: The facility reported a with one kitchen and a with one kitchen and a safe on observation review, the facility fail mechanical equipmer washers and 1 dishway condition by failing to lime buildup. Findings included: - Observations on 4/2 (Mountain Standard Ton each edge of the codors. Further observations on the edges temperature gauge, a solution connected to During an interview of Dietary Staff H confirmed the lime buildup from	, and patient care erating condition. It is not met as evidenced a census of 25 residents one laundry room. It, interview, and record ed to maintain essential at (2 industrial laundry asher) in safe operating keep the equipment free of the rinse basin, and opening where cleaning the dishwasher. In 4/3/12 at 5:41 p.m. MST, med staff failed to remove the dishwasher and	F	456	,		
	the lime. Although requested, t documentation of rem the dishwasher on the During an interview of	the facility failed to provide an acceptance of lime buildup from the cleaning schedule. In 4/4/12 at 2:21 p.m. MST, the senance/Laundry Staff S					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		17E071	B. WIN	IG		04/1	1/2012	
	COUNTY HOSPITAL LT	си		50	EET ADDRESS, CITY, STATE, ZIP CODE 06 THIRD PO BOX 338 RIBUNE, KS 67879	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 456	reported kitchen staff lime buildup from the Observations on 4/4/revealed lime buildup the front panel of two washers. Further obsapproximately a half ideposits around the translation connected to During an interview of Housekeeping/Maintereported staff remove de-liming cleanser on to remove the lime sind Although requested, the documentation of the schedule. The facility failed to mechanical equipment industrial laundry was	as responsible to remove dishwasher. 12 at 11:18 a.m. MST below each door and down of the two industrial laundry servations revealed inch buildup of mineral op opening where cleaning each washer. 12 at 11:18 a.m. MST below each down of the two industrial laundry servations revealed inch buildup of mineral op opening where cleaning each washer. 13 at 14:18 a.m. MST below each down industrial where all aundry stand a monthly basis but failed ince January 2012. 14 at 11:18 a.m. MST below each down industrial buildup of mineral laundry stand stand and the second industrial failed to provide monthly laundry cleaning industrial essential each, which included 2 shers and 1 dishwasher, in on by failing to keep the	F	456				